

## 11401 CERTIFICATE OF DEATH

11405

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cumberland		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 115 Humbird Street				115 Humbird Street			
3. NAME OF DECEASED (First) CARRIE		(Middle) JANE		(Last) ATHEY		4. DATE (Month) OF DEATH Dec. 27 (Dey) (Year) 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Apr. 1, 1883		9. AGE last birthday 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Allegany Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Himkle				14. MOTHER'S MAIDEN NAME Mary Wagner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Geo. F. Athey, Cumberland, Md.		115 Humbird Street	
18. MEDICAL CERTIFICATION  I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  420.1 IMMEDIATE CAUSE (A) Acute Coronary Occlusion ANTECEDENT CAUSE(S) DUE TO (B) Anterostenotic Cardio Vascular Disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Advanced Age  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) M.D. 133 Van Ave, Cumberland, Md.		(County) (State)	
21d. TIME OF INJURY (Month) (Dey) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? County medical affair notified?			
22. I hereby certify that I attended the deceased from August 19, 1954, to Dec. 19, 1955, that I last saw the deceased alive on Sept. 19, 1955, and that death occurred at 8:30 A.M. from the causes and on the date stated above. SIGNATURE J. O. Immen Wagner M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 31, 1955		NAME OF CEMETERY OR CREMATORIAL M.D. 133 Van Ave, Cumberland, Md.		LOCATION (City, town, or county) Cumberland, Maryland (State)	
24. REC'D BY REGISTRAR Dec. 31, 1955		REGISTRAR'S SIGNATURE Winter R. Foutz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		ADDRESS Cumberland, Maryland	

CERTIFICATE OF DEATH

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11406

## 11452 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Allegany Frostburg	MARYLAND LENGTH OF STAY (in this place) 4 Mos.	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Route 1, Frostburg, STREET ADDRESS (If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH Dec. 2nd, 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH April 11th, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	9. AGE last birthday 75 yrs. IF UNDER 1 YEAR Months Days Hours Min.
13. FATHER'S NAME James P. Brown		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		14. MOTHER'S MAIDEN NAME Christine Hott	
16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. Leslie Brode, Frostburg, Md.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO 260X		13 months Generalized arteriosclerosis - advanced Years Diabetes Mellitus	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 19, 1948, to Dec. 2, 1955, that I last saw the deceased alive on Dec. 1, 1955, and that death occurred at 5:10 A.M., from the causes and on the date stated above. SIGNATURE <i>John B. Davis</i> M.D. ADDRESS (Street, city, town, state) Frostburg, Maryland DATE SIGNED Dec. 2, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-4-1955	
24. REC'D BY REGISTRAR DATE 12-4-55		REGISTRAR'S SIGNATURE <i>Mrs. Nancy A. Rose</i>	
25. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		ADDRESS	

STATE DEPARTMENT  
CERTIFICATE OF DEATH

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**INSTRUCTIONS**

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**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

11407

**11402 CERTIFICATE OF DEATH**

Reg. Dist. No. 10

Item 1. Film G190 12-21-55 et

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY OR TOWN	<b>Allegany</b> Cumberland Mt. Savage	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY OR TOWN STREET ADDRESS
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Sacred Heart Hospital		Allegany Mt. Savage New Row
<b>3. NAME OF DECEASED (Type or Print)</b>		<b>4. DATE (Month) (Day) (Year)</b>	
(First) Frances		(Middle) Clara	
(Last) Barrett		Dec. 14th, 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH August 5th, 1892
9. AGE (at birthday) 63 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper	10b. KIND OF BUSINESS OR INDUSTRY Glenn Sav. Dairy	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME James E. Barrett		
14. MOTHER'S MÄDEN NAME Mary V. Lucky			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
16. SOCIAL SECURITY NO. 213-01-8665			17. INFORMANT & ADDRESS Mrs. Arthur Walsh, Mt. Savage, Md.
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 410X IMMEDIATE CAUSE (A) <i>RHEUMATIC HEART DISEASE</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 1997 YEARS			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>MITRAL REGURGITATION, ADVANCED</i> MANY YEARS			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, officia bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11/28</i> , 1955, to <i>12/14</i> , 1955, that I last saw the deceased alive on <i>12/14</i> , 1955, and that death occurred at <i>2:45 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>Arthur R. Rollins, M.D.</i> ADDRESS (Street, city, town, state) <i>42 Broadway - Frostburg, Md. 12/15/55</i> DATE SIGNED <i>12/15/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-17-55	NAME OF CEMETERY OR CREMATORIY St. Patrick's Cemetery
24. REC'D BY REGISTRAR DATE <i>Dec. 17, 1955</i>		REGISTRAR'S SIGNATURE <i>James M. Durst</i>	LOCATION (City, town, or county) Mt. Savage, Md.
25. FUNERAL DIRECTOR'S SIGNATURE DATE <i>Dec. 17, 1955</i>		ADDRESS Joseph R. Durst, Frostburg, Md.	

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

STATE OF DEATH

RECEIVED  
BUREAU OF INVESTIGATION  
MAY 1965

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11408

11453

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY TOWN	Allegany (If outside corporate limits, write RURAL and give nearest town) Frostburg,	MARYLAND LENGTH OF STAY (In this place) Lifetime	STATE CITY TOWN STREET ADDRESS
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Maryland COUNTY Allegany Frostburg, (If rural give location) 6 Chestnut Street	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) OF DEATH Dec. 1st, 1955 (Day) (Year)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH March 22nd, 1864
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	9. AGE last birthday 91 yr.
13. FATHER'S NAME Martin Knepp		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		14. MOTHER'S MAIDEN NAME Sarah Gowers	
(If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Mrs. David Kiddy, Frostburg, Md.		18. MEDICAL CERTIFICATION Cerebral hemorrhage arterio - sclerotic cardio- vascular disease Senility	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from 11-1-1955 to 12-1-1955, that I last saw the deceased alive on 12-1-1955, and that death occurred at 11 P.M. from the causes and on the date stated above. SIGNATURE H. C. Knepp		21f. HOW DID INJURY OCCUR?	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-4-1955	
24. REC'D BY REGISTRAR DATE 12-4-55		NAME OF CEMETERY OR CREMATORIUM Frostburg Memorial Park	
REGISTRAR'S SIGNATURE Mrs. Nancy H. Rose		LOCATION (City, town, or county) Frostburg, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		ADDRESS	

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FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

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RECEIVED  
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U. S. DEPARTMENT OF JUSTICE  
100-2000

FEDERAL BUREAU OF INVESTIGATION

DEC 7 1965

RECEIVED

11403

DR. HIMMELWRIGHT

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

## INSTRUCTIONS

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	ALLEGANY CUMBERLAND	STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	MARYLAND CUMBERLAND
LENGTH OF STAY (In this place) 35		COUNTY (If rural give location) ALLEGANY 1012 ELLA AVENUE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL		3. NAME OF DECEASED (First) ARTHUR (Middle) C. (Last) BROWN	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH JANUARY 21, 1904
9. AGE last birthday 51 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant</b> <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY Sykesville State Hospital	
13. FATHER'S NAME WILLIAM BROWN		11. BIRTHPLACE (State or foreign country) MARYLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		14. MOTHER'S MAIDEN NAME BETTY ALKIRE	
16. SOCIAL SECURITY NO. 220-10-2461		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>053.1</b> IMMEDIATE CAUSE ANTECEDENT CAUSE(S) <b>Topical</b> (A) <b>Empyema, Pericarditis, Peritonitis,</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <b>200x</b> (B) <b>Abcess left Kidney</b> DUE TO <b>fulminant Staphylococcus Septicemia.</b> (C) <b>Diabetes Mellitus - Uncontrolled.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>35 days</b>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) <b>133 Virginia Ave, Cumberland, Md.</b> (State) <b>Alta</b>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Oct. 19, 1955</b> to <b>Nov. 30, 1955</b> , that I last saw the deceased alive on <b>Nov. 30, 1955</b> , and that death occurred at <b>5:15 AM</b> , from the causes and on the date stated above.			
SIGNATURE <b>Dr. Weston Himmelwright</b>		ADDRESS (Street, city, town, state) <b>133 Virginia Ave, Cumberland, Md. Alta</b>	
DATE SIGNED <b>Oct. 2, 1955</b>		DATE SIGNED <b>Oct. 2, 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Dec. 3, 1955</b> NAME OF CEMETERY OR CREMATORIUM <b>Alkire Family Cemetery</b> LOCATION (City, town, or county) <b>near Fort Ashby, W. Va.</b>	
24. REC'D BY REGISTRAR <b>Dec. 2, 1955</b>		REGISTRAR'S SIGNATURE <b>Walter R. Tracy, M.D.</b> 25. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarbelli, Cumberland, Maryland</b>	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

STATE OF SOUTH CAROLINA  
GENERAL ASSEMBLY

1955-1956

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RECEIVED

11410

Reg. Dist.

No. 4

11404  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

COUNTY Allegany MARYLAND  
CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWN Cumberland LENGTH OF STAY  
(in this place)  
119 days

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS Sacred Heart Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany  
CITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWN Cumberland

STREET ADDRESS (If rural, give location)  
624 Washington St.

3. NAME OF  
DECEASED:  
(Type or Print)

(First) Mary (Middle) Elizabeth (Last) Cain

4. DATE  
(Month) (Day) (Year)  
OF  
DEATH Dec. 13 1955

5. SEX:  
female

6. COLOR OR  
RACE:  
white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify) widow

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired)  
Housewife

10b. KIND OF BUSINESS OR  
INDUSTRY:  
Own Name

11. BIRTHPLACE (State or foreign country): Brooklyn, N.Y.

12. CITIZEN OF WHAT  
COUNTRY? U.S.A.

13. FATHER'S NAME:  
John C. Gillespie

14. MOTHER'S MAIDEN NAME:  
Mary Canecon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, No, or unk.) (If Yes, give war or dates of  
service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS:  
Sacred Heart Hospital

18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1  
Immediate cause (a) Myocardial failure  
DUE TO

Antecedent cause(s) (b) Arteriosclerosis  
Diseases or conditions, if any. (b) DUE TO

giving rise to the above cause  
stating underlying cause last (c)

gradual  
several  
years.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

Fracture of the right humerus

since Aug. 16/55

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes  No

21a. EXTERNAL CAUSE WAS PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH.

21b. PLACE (Home, farm, factory,  
OF street, office, bldg., etc.) INJURY None

21c. (City or town) (County) (State)

Cumberland Allegany Md.

21d. TIME (Month) (Year) 12 (Hrs) 21e. INJURY OCCURRED  
OF INJURY Aug. 16-1955 A.M. While at Not while  
work  at work

21f. HOW DID INJURY OCCUR? Sitting on side of  
bed & fell to the floor.

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and

find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

SIGNATURE H.V. Deming M.D.

CHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
ASSISTANT MEDICAL EXAM.

DATE SIGNED Dec. 13-1955

23. BURIAL, CREMATION,  
REMOVAL (Specify): Burial

DATE THEREOF Dec. 16, 1955

NAME OF CEMETERY OR CREMATORIUM St. Peter and Paul Cemetery, Cumberland, Maryland

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. OFFICER Dec. 17, 1955

REG. OFFICER Charles R. Tracy, M.D.

REG. OFFICER James T. Scarpelli, M.D.

REG. OFFICER Scarpelli

3. A 1

3. A 2

**11405 CERTIFICATE OF DEATH**

Reg. Diet. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>ALLEGANY</b>		MARYLAND		STATE <b>PA.</b>	COUNTY <b>BEDFORD</b>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>CUMBERLAND</b>		LENGTH OF STAY (in this place) <b>9 1/4 HOURS</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>BEDFORD</b>		STREET ADDRESS (If rural give location) <b>340 W. PITT ST.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>				3. NAME OF DECEASED (Type or Print) <b>BABY GIRL</b>			
4. DATE OF DEATH <b>12 12 1955</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>CLAYCOMB</b>	
8. DATE OF BIRTH <b>12-11-55</b>		9. AGE last birthday yrs. <b>12</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>CLAYCOMB, LANDON D.</b>		14. MOTHER'S MAIDEN NAME <b>SILL, JEAN L.</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>MEMORIAL HOSPITAL</b>		18. MEDICAL CERTIFICATION <b>Prenativity</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>776X</b>				INTERVAL BETWEEN ONSET AND DEATH <b>9 hrs 45m</b>			
IMMEDIATE CAUSE <b>(A)</b>				ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, <b>(B)</b> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, <b>(C)</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>12/11/1955</b> to <b>12/12/1955</b> , that I last saw the deceased alive on <b>12/11/1955</b> , and that death occurred at <b>1:10 A.M.</b> from the causes and on the date stated above. SIGNATURE <b>W.P. Hodges</b> ADDRESS (Street, city, town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>12/13/1955</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		DATE THEREOF <b>Dec. 14, 1955</b>		NAME OF CEMETERY OR CREMATORIAL <b>Memorial Hospital</b>		LOCATION (City, town, or county) <b>Cumberland, Maryland.</b>	
24. REC'D BY REGISTRAR <b>Dec. 14, 1955</b>		REGISTRAR'S SIGNATURE <b>Winter R. Frazer, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Memorial Hospital, Cumberland, Maryland.</b>		ADDRESS	

## ATTENDING PHYSICIAN OR HOSPITAL

The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the attending physician and completely filled out. The death certificate assembly should be detached for use as a burial transit permit.

Death certificates

SA 5  
1970

With corporate limits

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 IOM

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11412

11406 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED						
COUNTY		MARYLAND		STATE Maryland		COUNTY Allegany				
CITY (If outside corporate limits, write RURAL OR give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If rural give location)				
02 Town		70 yrs		02 Cumberland, Md.		112 So. Liberty St.				
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 112 So. Liberty St.				STREET ADDRESS						
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH						
(First)		(Middle)		(Last)		(Month)	(Day)	(Year)		
Mary		P.		Conley		12	3	1955		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS			
F	W	Widowed	Dec. 5, 1877	77 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)				
Housewife			Omniture			Pittsburg, Pa.				
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME						
John T. Parker				Bridgett E. Deavy						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS				
No				None		John T. Conley 112 So. Liberty				
18. MEDICAL CERTIFICATION										
151X IMMEDIATE CAUSE (A) <i>Carcinoma, stomach</i>										
ANTECEDENT CAUSE(S) DUE TO										
DISEASES OR CONDITIONS, IF ANY, (B)										
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)										
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.										
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town)			(County)	(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <i>Sept. 1, 1955</i> , to <i>Oct. 3, 1955</i> , that I last saw the deceased alive on <i>Sept. 1, 1955</i> , and that death occurred at <i>10:45 A.M.</i> from the causes and on the date stated above.									ADDRESS (Street, city, town, state)	DATE SIGNED <i>10/3/55</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM			LOCATION (City, town, or county)			
Burial		12-7-55		St Peter and Paul Cem			Cumberland, Md.			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS			
Dec. 5, 1955		Walter F. Frank, M.D.		James F. Scarpelli			Cumberland, Md.			

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**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 155 10W

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11407 CERTIFICATE OF DEATH

11413

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>		
COUNTY	ALLEGHENY	MARYLAND	STATE	Md.	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)			CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN	Cumberland		TOWN	Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Sacred Heart Hospital		STREET ADDRESS	652 Fayette St.	
<b>3. NAME OF DECEASED</b> (First) Rex LeClare Cope			<b>4. DATE OF DEATH</b> Dec. 26 1955		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months Days Hours Min
Male	White		11/23/1901	64 yrs.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
			St. Roads Comm.	Penna. DuBois	U. S.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Elmer Cope (Deceased)			Julia (Thompson) Cope (Deceased)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
				652 Fayette St., McFee--Chart Mts., Bel Air, Md.	
<b>18. MEDICAL CERTIFICATION</b>					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
153x IMMEDIATE CAUSE (A) <i>Chromosomal of colon</i>					
ANTECEDENT CAUSE(S) DUE TO					
DISEASES OR CONDITIONS, IF ANY, (B) _____					
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
19c. DATE OF OPERATION		19d. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Dec. 21, 1955</i> to <i>Dec. 26, 1955</i> , that I last saw the deceased alive on <i>Dec. 26, 1955</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above. SIGNATURE <i>R. M. Schindler M.D.</i> ADDRESS (Street, city, town, state) <i>41 Ernest Calvert Rd</i> DATE SIGNED <i>1/1/72</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/28/55		NAME OF CEMETERY OR CREMATORIAL S. S. Peter & Pauls Cemetery	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Walter R. Frank, M.D.</i>		LOCATION (City, town, or county) Cumberland, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Charles L. George Cumberland, Md.			
DATE 28, 1955					

330

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11408 CERTIFICATE OF DEATH

11414

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY		ALLEGANY		STATE		MARYLAND COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN		CUMBERLAND		LENGTH OF STAY (In this place)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				22 HRS.		STREET ADDRESS (If rural give location)	
MEMORIAL HOSPITAL						703 ELM STREET	
<b>3. NAME OF DECEASED</b> (First) JOHN (Middle) F (Last) COUTER				<b>4. DATE OF DEATH</b> DECEMBER 12, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	MARRIED	8. DATE OF BIRTH	1879	9. AGE last birthday	76 yrs.
MALE	WHITE			SEPTEMBER 17		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Mill-Wright				B.& O.R.R.		MARYLAND	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
GEORGE COUTER				MARGARET REID			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.			
NO				705-05-4598			
17. INFORMANT & ADDRESS				18. MEDICAL CERTIFICATION			
MEMORIAL HOSPITAL				INTERVAL BETWEEN ONSET AND DEATH			
MEMORIAL AND WARWICK AVENUES				Years.			
<b>I</b> DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4114 IMMEDIATE CAUSE (A) Congestive Heart Failure - Acute 10 min.							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, (B) Hyper Tension Cardi Vascular Disease Years.							
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C) Chronic Myocarditis							
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)					
21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. HOW DID INJURY OCCUR?					
M.		While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from August 1954 to Dec 1955, that I last saw the deceased alive on Dec 12, 1955, and that death occurred at 2:20 P.M. from the causes and on the date stated above.							
SIGNATURE <i>John C. Couter, M.D.</i> ADDRESS (Street, city, town, state) 133 Virgin Ave, Cumberland, Md. DATE/SIGNED 12/13/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec 15 1955		NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		LOCATION (City, town, or county) Cumberland, Md. (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Charles A. Frank, M.D.</i>					
NOTE: 14, 1955		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS					
		Byron Kight, Cumberland, Md.					

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11459

11415

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 23

## 1. PLACE OF DEATH:

COUNTY Allegany MARYLAND  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN Cumberland, Md.

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS Town Hill Route 40

3. NAME OF  
 DECEASED: (First) Robert (Middle) Miller (Last) Dahl  
 (Type or Print)

4. SEX: male 6. COLOR OR  
 RACE: white 7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED.  
 (Specify) Single 8. DATE OF BIRTH: Aug. 26-1933 9. AGE last birthday: 22 IF UNDER 1 YEAR  
 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of  
 work done during most of work life,  
 even if retired) Miner 10b. KIND OF BUSINESS OR  
 INDUSTRY: Steel

## 13. FATHER'S NAME:

Leslie E. Dahl

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes 16. SOCIAL SECURITY NO.: 1954 855 471-30-2350

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Minnesota COUNTY  
 CITY (If outside corporate limits write RURAL and give nearest town)  
 OR TOWN Minneapolis

STREET ADDRESS 3754 Edmund Blvd. (If rural, give location)

4. DATE OF DEATH Dec. 5 1955

11. BIRTHPLACE (State or foreign country): St. Cloud, Minn. 12. CITIZEN OF WHAT  
 COUNTRY? U.S.A.

## 14. MOTHER'S MAIDEN NAME:

Irene Miller

17. INFORMANT & ADDRESS: Leslie H. Dahl  
 (father) Minneapolis, Minn.

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

823X  
 Immediate cause (a) Intracranial hemorrhage DUE TO

INTERVAL BETWEEN  
 ONSET AND DEATH  
 sudden

Antecedent cause(s)  
 Diseases or conditions, if any, giving rise to the above cause DUE TO  
 stating underlying cause last (b) fractured skull also had fractured right femur  
(c) (auto accident) and lacerations of scalp.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?  
 Yes  No

21a. EXTERNAL CAUSE WAS PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH.

21d. TIME (Month) (Day) (Year) 5 30 1955 21e. INJURY OCCURRED OF INJURY While at work Not while at work

(Town Hill)

21c. (City or town) Cumberland (County) Allegany (State) Md.

21f. HOW DID INJURY OCCUR? Lost control of auto, hit guard rails, thrown out.

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

SIGNATURE

H. V. Denning M.D.

CHIEF MEDICAL EXAMINER  
 DEPUTY MEDICAL EXAMINER  
 M. D. ASSISTANT MEDICAL EXAM.

DATE SIGNED  
 Dec. 5-1955

23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county) (State)  
 Removal (Specify) Burial 12/8/55 Acacia Memorial Park Minneapolis Minnesota

DATE REC'D. BY LOCAL REG. OFFICER Dec. 5, 1955 INSPECTOR'S SIGNATURE H. V. Denning

24. FUNERAL DIRECTOR ADDRESS  
 Name John Stein Inc. Cumber M.D.  
 Stein

MARGIN RESERVED FOR INK  
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct  
 age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

DEC 12 1955

RECEIVED

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18****11416**

Item 21 Film G191 1-13-56 am

**11409 CERTIFICATE OF DEATH**Reg. Dist. No. *4*

<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>		
COUNTY <b>Allegany</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <b>Cumberland</b>		Lifetime		TOWN <b>Cumberland, Rural</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		
<b>Memorial Hospital (D.O.A.)</b>			<b>R.F.D. #1 LaVale, Md.</b>		
(First) <b>Deborah</b> (Middle) <b>Sue</b> (Last) <b>Dean</b>			<b>4. DATE (Month) (Day) (Year)</b> <b>12-29-55</b>		
S. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>12-7-54</b>	9. AGE last birthday <b>I</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Ds <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	
13. FATHER'S NAME <b>Alford Dean</b>			14. MOTHER'S MAIDEN NAME <b>Philos McCarty</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT & ADDRESS <b>Alford Dean R.F.D. #1 LaVale, Md.</b>	
<b>18. MEDICAL CERTIFICATION</b>					
<p>I. IMMEDIATE CAUSE <b>Asphyxiation due to aspiration of gastric contents</b></p> <p>ANTECEDENT CAUSE(S) DUE TO <b>Enteritis</b></p> <p>DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO <b>Stating underlying cause last.</b></p> <p>STATING UNDERLYING CAUSE LAST. DUE TO <b>(C)</b></p>					
INTERVAL BETWEEN ONSET AND DEATH					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <b>home</b>		21c. WHERE DID INJURY OCCUR? (City or town) <b>(County) Allegany (State)</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED <b>M. at work</b> <b>White</b> <b>Not white</b> <b>at work</b>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Dec. 27, 1955</b> to <b>Dec. 29, 1955</b> , that I last saw the deceased alive on <b>Dec. 27, 1955</b> , and that death occurred at <b>8:00 A.M.</b> from the causes and on the date stated above.					
SIGNATURE <i>Alphonse Wrightson</i> ADDRESS (Street, city, town, state) <b>M.D. 133 W. Ave Cumberland, Md.</b> DATE SIGNED <b>12/30/55</b>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>12-31-55</b>		NAME OF CEMETERY OR CREMATORIAL <b>Hillcrest Burial Park</b> LOCATION (City, town, or county) <b>Cumberland, Md.</b> (State)	
24. REC'D BY REGISTRAR <b>Dec. 31, 1955</b>		REGISTRAR'S SIGNATURE <i>Winter L. Frank, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarielli</b> ADDRESS <b>James F. Scarielli Cumberland, Md.</b>	

24

25

## INSTRUCTIONS

1. When or corporate limits  
2. At this time or corporate limits  
3. After this time or corporate limits

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11410 CERTIFICATE OF DEATH

11417

Reg. Dist. No. 4

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)	Allegany	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland	COUNTY Allegany	CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Cumberland		8 days	TOWN Westernport		43
HOSPITAL OR INSTITUTION OR STREET ADDRESS IX	Sylvan Retreat		STREET ADDRESS		(If rural give location)
3. NAME OF DECEASED (Type or Print)			4. DATE (Month) (Day) (Year)		
Lawrence			Densmore Dec. 13 1955		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M	8. DATE OF BIRTH Sept. 25, 1884	9. AGE last birthday 71 yrs.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B&O Blacksmith helper			10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Newburg, West Virginia.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Lawrence Densmore			14. MOTHER'S MAIDEN NAME Virginia Stone		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No			16. SOCIAL SECURITY NO.		
17. INFORMANT & ADDRESS Genevie Densmore (wife)			18. MEDICAL CERTIFICATION Pulmonary Hypostasis Chronic Myolitis Cerebral arteriosclerosis Senile psychosis		
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OR INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work Not while at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec. 5, 1955, to Dec. 13, 1955, that I last saw the deceased alive on Dec. 12, 1955, and that death occurred at 1:10 A.M. from the causes and on the date stated above. SIGNATURE James C. McLean M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 15, 1955		ADDRESS (Street, city, town, state) 49 Greece St. DATE SIGNED 12-13-55	
24. REC'D BY REGISTRAR Dec. 14, 1955		REGISTRAR'S SIGNATURE Walter R. Gandy, M.D.		LOCATION (City, town, or county) Westernport, Maryland. (State)	
25. FUNERAL DIRECTOR'S SIGNATURE Ellsworth S. Boal, Westernport, Maryland.				ADDRESS	

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**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the register within 72 hours after death. After this certificate has been executed by the attending physician and completed, filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

11418

**11454 CERTIFICATE OF DEATH**

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>		
COUNTY <b>Allegany</b>		MARYLAND	STATE <b>Maryland</b>		COUNTY <b>Allegany</b>
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN <b>Frostburg</b>		3 weeks	TOWN <b>Triple Lakes, Cresaptown</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Miner's Hospital</b>			STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED (First) <b>Annie</b> (Middle) <b>Susan</b> (Last) <b>Dixon</b>			4. DATE (Month) <b>Dec.</b> (Day) <b>4th</b> , (Year) <b>19 55</b>		
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	B. DATE OF BIRTH <b>March 4th, 1882</b>	9. AGE last birthday <b>73</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
13. FATHER'S NAME <b>Columbus Paugh</b>			14. MOTHER'S MAIDEN NAME <b>Lucy Kitzmiller</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>Yes</b> (If Yes, give war or date of service) <b>None</b>			16. SOCIAL SECURITY NO. <b>Mrs. Naomi Dixon, Rt. 2, Frostburg</b>		
17. INFORMANT & ADDRESS <b>None</b>			18. MEDICAL CERTIFICATION		
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>180X</b> IMMEDIATE CAUSE <b>(A) Cervical Tidneys</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>		
ANTECEDENT CAUSE(S) DUE TO <b>(B) metastatic Ca. throughout</b>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <b>(C) in entire body</b>					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>(If either, NOTIFY MEDICAL EXAMINER)</b>			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21c. WHERE DID INJURY OCCUR? (City or town) <b>Frostburg</b> (County) <b>Md.</b> (State) <b>Md.</b>					
21d. TIME OF INJURY (Month) <b>0</b> (Day) <b>19</b> (Year) <b>55</b> (Hour) <b>11</b>			21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <b>11/11/1955</b> to <b>12/4/1955</b> , that I last saw the deceased alive on <b>12/1/1955</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above. SIGNATURE <b>John B. Davis, M.D.</b> ADDRESS (Street, city, town, state) <b>Frostburg, Md.</b> DATE SIGNED <b>12/1/1955</b>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>12-8-1955</b>	NAME OF CEMETERY OR CREMATORIAL <b>F'bg. Memorial Park</b>	LOCATION (City, town, or county) <b>Frostburg</b>	(State) <b>Md.</b>
24. REC'D BY REGISTRAR DATE <b>12-8-55</b>			REGISTRAR'S SIGNATURE <b>Johnnae A. Roe</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Joseph R. Durst, Frostburg, Md.</b>	

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**INSTRUCTIONS**

1. Within corporate limits  
2. Outside corporate limits  
3. Burial, cremation, removal (Specify)

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy or the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 4-5 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

11419

**11411 CERTIFICATE OF DEATH**

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY ALLEGANY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN CUMBERLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN RT. 1 RAWLINGS		
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL			STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED (Type or Print) NIMROD			4. DATE (Month) (Day) (Year) OF DEATH DEC. 26 1955		
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MARCH 6, 1878	9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner			10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	11. BIRTHPLACE (State or foreign country) Westernport, Maryland	
13. FATHER'S NAME THORNTON DUCKWORTH			14. MOTHER'S MAIDEN NAME OLIVE MILLER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) <input checked="" type="checkbox"/> (If Yes, give war or dates of service) MIA No			16. SOCIAL SECURITY NO.		
17. INFORMANT & ADDRESS MEMORIAL HOSPITAL			18. MEDICAL CERTIFICATION 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <i>Carcinoma of digestive flexure of Colon 6 mos.</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____ 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Metastatic carcinoma to liver</i>		
19a. DATE OF OPERATION 12-3-55			19b. MAJOR FINDINGS OF OPERATION <i>Carcinoma of Colon - metastasis</i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.) 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>12-3</u> <u>1955</u> to <u>12-26</u> <u>1955</u> , that I last saw the deceased alive on <u>12-25</u> , <u>1955</u> , and that death occurred at <u>12:05 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>W. F. Gratz</u> ADDRESS (Street, city, town, state) <u>122 S. Centre St. Cumberland, Md.</u> DATE SIGNED <u>12-27-55</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 28, 1955		NAME OF CEMETERY OR CREMATORIAL Philos Cemetery	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. F. Gratz, M.D.</u>		LOCATION (City, town, or county) Westernport, Maryland. ADDRESS	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth S. Boal, Westernport, Maryland.</u>					

REFUGEE  
CAMP

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10/M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11455 CERTIFICATE OF DEATH

11420

Reg. Dist. No. 6

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY	Allegany	STATE	Maryland
CITY (If outside corporal limits, write RURAL or and give nearest town)	MARYLAND	CITY (If outside corporal limits, write RURAL and give nearest town)	COUNTY Allegany
TOWN	Westernport	TOWN	Westernport
HOSPITAL OR INSTITUTION OR STREET ADDRESS	101 Howard St.	STREET ADDRESS	(If rural give location)
3. NAME OF DECEASED (First) (Middle) (Last)	George Ellis		
4. DATE OF DEATH (Month) (Day) (Year)	Dec 19 1955		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Male	White	Widower	27 Dec 1881
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
73 yrs.	Merchant ret.	Grocery Store	US
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Juad Ellis	Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.		
No	None		
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
Poland G. Ellis, Westernport		Cerebral Hemorrhage Arterio-sclerosis and Hypertension Prosthetic Hypertrophy	
INTERVAL BETWEEN ONSET AND DEATH		15 Minutes 2 Years 1 Year	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		19. MAJOR FINDINGS OF OPERATION	
22IX. IMMEDIATE CAUSE (A)		None	
ANTECEDENT CAUSE(S) DUE TO		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE, DUE TO		(C)	
STATING UNDERLYING CAUSE LAST.		21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21a. TIME OF INJURY (Month) (Day) (Year) (Hour)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
M. at work		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. INJURY OCCURRED While Not while at work		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Apr. 2, 1955, to Dec. 19, 1955, that I last saw the deceased alive on Dec. 14, 1955, and that death occurred at 4:45 A.M. from the causes and on the date stated above.			
Paul D. Wilson		ADDRESS (Street, city, town, state)	
M.D.		DATE SIGNED Dec. 26, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		NAME OF CEMETERY OR CREMATORIAL	
24. REC'D BY REGISTRAR		LOCATION (City, town, or county)	
DATE 12 21 55		(State)	
REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
Mrs. Jean C. Kelly		ADDRESS	
El Baval		Westernport, Md.	

DEC

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. This law applies to all deaths occurring within the state of Maryland. This certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5-59

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11421

## 11460 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Allegany	MARYLAND	STATE Maryland
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Nearown Cumberland, rural	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Rt. #3, Bedford Road	71 yrs	OR TOWN Near Cumberland, rural
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH Dec. 9 1955	
(First) Nine Fey		(Middle)	(Last)
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
F	W	Single	June 9, 1884
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if part-time)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
71 yrs.	Retired Hairdresser	Cumberland, Md.	USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
John T. Fey	Jennie Wilkinson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES?	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
(Yes, no, or unk.) No	513-42-3676	Ethelle Fey Cumberland, Md.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.0 IMMEDIATE CAUSE (A) <u>Acute myocardial failure</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute Coronary Insufficiency</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Coronary Sclerosis + Old Coronary</u>			
<u>Hypertensive and atherosclerotic Heart Disease</u>			
10 years			
10 years			
INTERVAL BETWEEN ONSET AND DEATH			
Immediate			
Immediate			
10 years			
10 years			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1947</u> to <u>9 Dec</u> , <u>1955</u> , that I last saw the deceased alive on <u>Nov 22</u> , <u>1955</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Ruelle G. Wessman, M.D.</u> ADDRESS <u>59 Green St Cumberland, Md.</u> DATE SIGNED <u>12/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORI
Burial		12/12/55	Rose Hill
24. REC'D BY REGISTRAR		LOCATION (City, town, or county) (State)	
		Cumberland, Md.	
REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
<u>Dec. 12, 1955</u>		<u>Winter R. Frantz, M.D.</u> H. Lee Silcox Cumberland, Md.	

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RECEIVED

11412

## CERTIFICATE OF DEATH

Reg. Dist. No....

9

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC I-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Allegany</b> CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>TOWN Frostburg</b>		STATE <b>Md.</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Frostburg</b> STREET ADDRESS <b>Frostburg</b> (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Miners Hospital</b>		R.D. # <b>Vale Summit</b>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<b>ANDREW</b> (First) <b>HENRY</b> (Middle) <b>FINN</b> (Last)		(Month) <b>Dec.</b> (Day) <b>28</b> (Year) <b>1955</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>12 - 10 - 1874</b>
9. AGE last birthday <b>81</b> yrs.	10. IF UNDER 1 YEAR <b>Months</b>	11. IF UNDER 24 HRS. <b>Deys</b>	12. IF UNDER 24 HRS. <b>Hours</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Room Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Vale Summit, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Finn</b>		14. MOTHER'S MAIDEN NAME <b>Jeanette Hawthorne</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT & ADDRESS <b>183 Mechanic St., Md.</b>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (A) <b>myocardial insufficiency</b> (B) <b>artery sclerosis</b> (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) <b>Frostburg, Md.</b> (County) <b>Md.</b> (State)		21d. TIME OF INJURY (Month) <b>Dec.</b> (Day) <b>24</b> , (Year) <b>1955</b> (Hour)	
21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Dec. 24, 1955</b> , to <b>Dec. 28, 1955</b> , that I last saw the deceased alive on <b>Dec. 28, 1955</b> , and that death occurred at <b>10:50 A.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>WOMC Lane</b>		ADDRESS (Street, city, town, state) <b>Frostburg, Md.</b> DATE SIGNED <b>Dec. 30, 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>12-31-55</b> NAME OF CEMETERY OR Crematory <b>St. Michaels Catholic</b> LOCATION (City, town, or county) <b>Frostburg</b> (State) <b>Md.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <b>Mary N. Riz</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>B.H. Montesant</b> ADDRESS <b>23 E. Main</b> Frostburg, Md.	
DATE <b>12-31-55</b>		REGISTRAR'S SIGNATURE <b>Mary N. Riz</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>B.H. Montesant</b> ADDRESS <b>23 E. Main</b> Frostburg, Md.	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11423

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

COUNTY Allegany MARYLAND  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN Luke

LENGTH OF STAY  
 (in this place)  
 8 hrs.

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS W. Va. Pulp & Paper Co. Plant.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany  
 CITY (If outside corporate limits write RURAL and give nearest town)  
 OR  
 TOWN Westernport

STREET ADDRESS (If rural, give location)  
 513 B. Md. Ave.

3. NAME OF  
 DECEASED:  
 (First) (Middle) (Last)

Joseph P. Francis

4. DATE  
 OF  
 DEATH Dec. 7 1955

5. SEX: 6. COLOR OR  
 RACE: 7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED  
 (Specify): married

10a. USUAL OCCUPATION (Give kind of  
 work done during most of work life,  
 even if retired): Paper Worker

10b. KIND OF BUSINESS OR  
 INDUSTRY: W. Va. P & P. Co.

8. DATE OF BIRTH: April 27-1907

9. AGE last birthday: 48 yrs.

IF UNDER 1 YEAR  
 Months Days Hours Min.

13. FATHER'S NAME:

Joseph Francis

11. BIRTHPLACE (State or foreign country): Westernport, Md.

12. CITIZEN OF WHAT  
 COUNTRY? U.S.A.

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
 (Yes, no, or unk.) (If Yes, give war or dates of  
 service)

16. SOCIAL SECURITY NO.: 217-05-0428

17. INFORMANT & ADDRESS: Dr. Best & Jacobson at  
 Memorial Hospital - records, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN  
 ONSET AND DEATH  
 sudden  
 about 5  
 years.

Immediate cause (a) Coronary occlusion

DUE TO

Antecedent cause(s) (b) Chronic myocarditis with

Diseases or conditions, if any, (b)  
 giving rise to the above cause  
 stating underlying cause last

DUE TO

(c) Coronary sclerosis.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes  No

21a. EXTERNAL CAUSE WAS  
 PRIMARY  or CONTRIBUTING  CAUSE OF DEATH.

21b. PLACE (Home, farm, factory,  
 of street, office bldg., etc.)  
 INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour)  
 OF INJURY M.

21e. INJURY OCCURRED  
 While at work  Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and  
 find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

SIGNATURE  
 H.V. Deming M.D. 11. V. Deming M.D.

CHIEF MEDICAL EXAMINER  
 DEPUTY MEDICAL EXAMINER  
 ASSISTANT MEDICAL EXAM.

DATE SIGNED  
 Dec. 7-1955

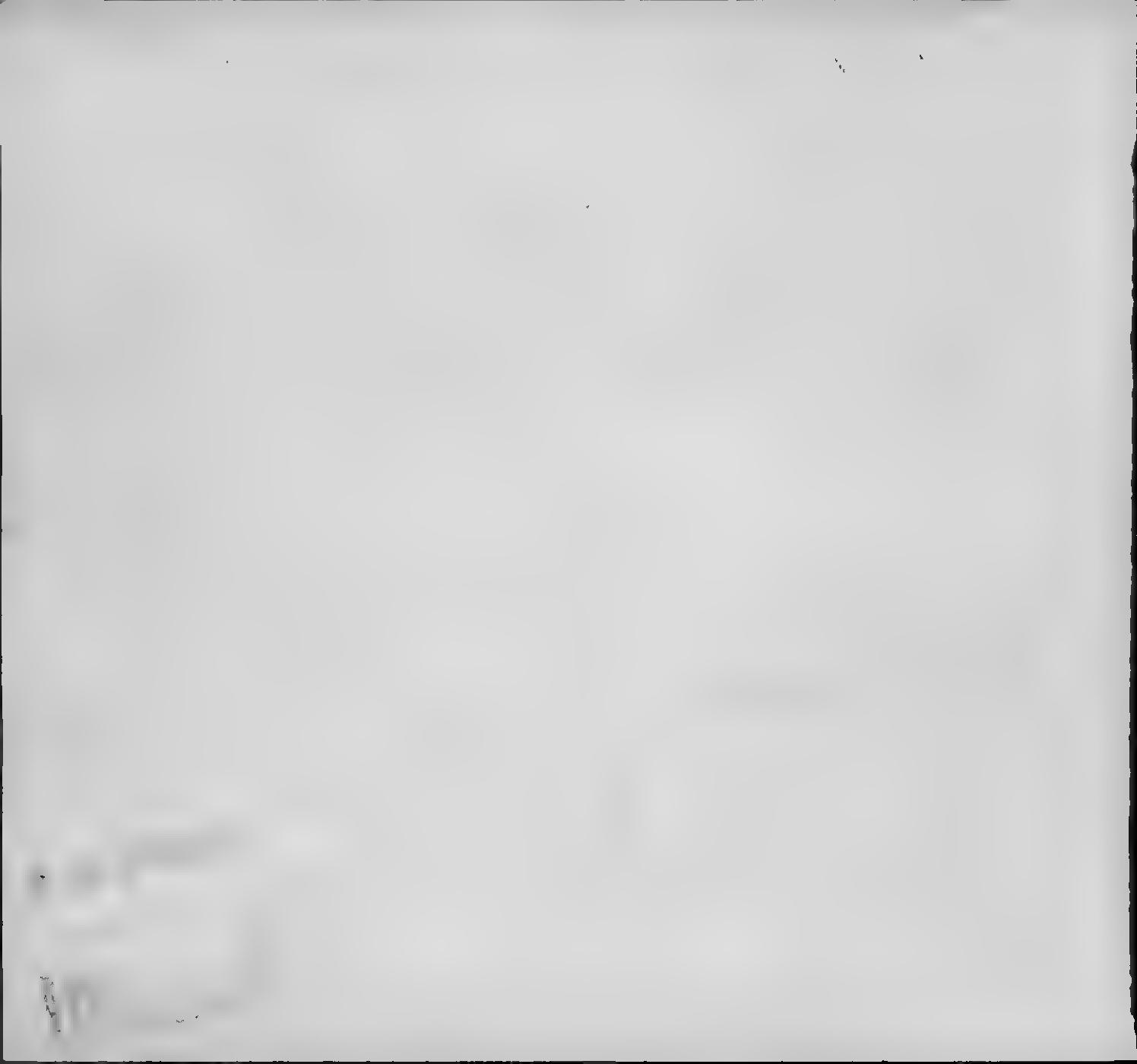
23. BURIAL, CREMATION,  
 REMOVAL (Specify): Burial

DATE THEREOF 12/10/55

NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)  
 St. Peters Cemetery Westernport Alleg. Md.

DATE REC'D BY LOCAL REG. 12-9-55

REG. DATE REC



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A151-155 10M

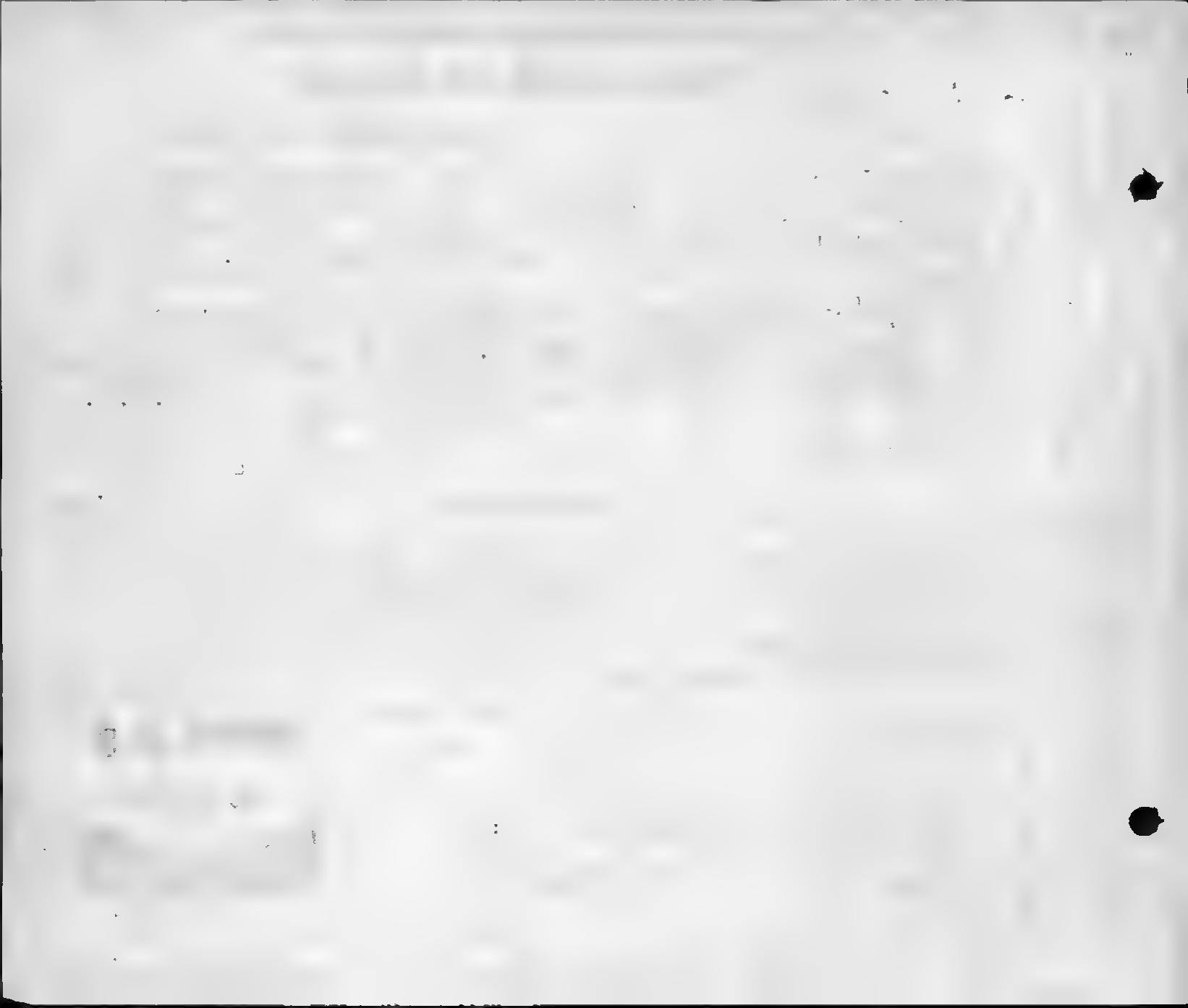
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11424

## 11413 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED							
COUNTY	ALLEGANY		MARYLAND	STATE	MARYLAND		COUNTY	ALLEGANY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)			LENGTH OF STAY (In this place)	TOWN	CUMBERLAND		CITY (If outside corporate limits, write RURAL and give nearest town)				
TOWN	CUMBERLAND,		10 DAYS				TOWN	CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS	MEMORIAL HOSPITAL			STREET ADDRESS			(If rural give location)				
3. NAME OF DECEASED (Type or Print)				(First)	(Middle)	(Last)	4. DATE (Month) (Day) (Year)				
				RALPH	E	GANTT	DEC.	13,	1955		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.				
MALE	WHITE	MARRIED	NOV. 9 1889	66 yrs.	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?		
Setting monuments				Monument Dealer	Frostburg MARYLAND				U. S. A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
GANTT, CONRAD				PARKER, RACHEL							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS						
NO				214905-7599	MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVES.						
18. MEDICAL CERTIFICATION										INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										4 days	
2. IMMEDIATE CAUSE (A) BRONCHOPNEUMONIA										10 days	
ANTECEDENT CAUSE(S) DUE TO Hypostasis secondary to										10 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Cerebral Thrombosis										3 years	
(C) Arterosclerosis, general											
III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.											
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from.....										74, 1954, to Dec. 13, 1955, that I last saw the deceased	
alive on Dec. 13, 1955, and that death occurred at 9:12 P.M. from the causes and on the date stated above.										ADDRESS (Street, city, town, state)	
SIGNATURE										DATE SIGNED 16/1/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIY				LOCATION (City, town, or county) (State)			
Burial		Dec 16 1955		St Luke's Cemetery				Cumberland Md.			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
Dec 15, 1955		Walter F. Haas, M.D.		Byron Kight, Cumberland, Md.							



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11425

## 11414 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		ALLEGANY CUMBERLAND	MARYLAND LENGTH OF STAY (In this place) 35 MINUTES		STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,			COUNTY ALLEGANY CORRIGANSVILLE X		
3. NAME OF (First) (Middle) (Last) DECEASED (Type or Print) MARY ELIZABETH GOLDEN			4. DATE (Month) (Day) (Year) OF DEATH DECEMBER 8 1955		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH MARCH 12 1887	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) PENNA	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME WEST SMITH			14. MOTHER'S MAIDEN NAME RACHAEL WALLMAN Bowser		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT & ADDRESS William Golden Corriganville			18. MEDICAL CERTIFICATION Acute Coronary Occlusion Hypertensive Cardio Vascular Disease Atherosclerosis		
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C)			INTERVAL BETWEEN ONSET AND DEATH no years.		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. DATE OF OPERATION		21b. MAJOR FINDINGS OF OPERATION		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21e. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21f. HOW DID INJURY OCCUR?	
21g. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21h. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>55</u> , to <u>Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 8</u> , 19 <u>55</u> , and that death occurred at <u>2:20 P.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>Dr. Weston F. Tracy, M.D.</u>			ADDRESS (Street, city, town, state) <u>133 1/2 Lee, Cumberland, Md 12/1/55</u>		DATE SIGNED <u>12/1/55</u>
23. BUR. AL., CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 11, 1955		NAME OF CEMETERY OR CREMATORIUM Hendman Cemetery	
24. REC'D BY REGISTRAR Dec. 11, 1955		REGISTRAR'S SIGNATURE Winter R. Tracy, O. D. Lawrence		25. FUNERAL DIRECTOR'S SIGNATURE Hendman, Pa	
ADDRESS <u>133 1/2 Lee, Cumberland, Md 12/1/55</u>		ADDRESS <u>Winter R. Tracy, O. D. Lawrence, Hendman, Pa</u>		ADDRESS <u>Hendman, Pa</u>	

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BUREAU V. S.

DEC 14 1965

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate **assimably** should be delivered to us as **Funeral transit permit.**

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11426

## 11462 CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY <b>Allegheny</b>		MARYLAND	STATE <b>Maryland</b>		COUNTY <b>Allegheny</b>
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		RURAL <b>Flintstone</b>
TOWN <b>Flintstone</b>			STREET ADDRESS		(If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<b>R.D. # 2</b>	<b>R.D. # 2</b>		
3. NAME OF DECEASED (Type or Print) <b>Mary Ellen Cordon</b>			4. DATE (Month) (Day) (Year) <b>Dec. 17 19</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>5-16-1875</b>	9. AGE last birthday <b>80 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>o-sew wife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Bedford Co. Penna.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Martin J. Wilson</b>			14. MOTHER'S MAIDEN NAME <b>Emily Bennett</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>123-45-6789</b>		17. INFORMANT & ADDRESS <b>Martin J. Cordon 123 Flintstone</b>	
18. MEDICAL CERTIFICATION <b>Central Hemorrhage 16-1- apertus clausus</b>					
INTERVAL BETWEEN ONSET AND DEATH					
19a. IMMEDIATE CAUSE (A) <b>Central Hemorrhage 16-1- apertus clausus</b>			19b. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>Antecedent cause</b>		
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <b>Antecedent cause</b>			19c. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19d. DATE OF OPERATION		19e. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY sheet, office bldg., etc.) <b>Green Meadow Inn</b>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <b>Flintstone, Allegheny, Pa.</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>M.</b>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>5-16-1875</b>	
22. I hereby certify that I attended the deceased from <b>12-16-1875</b> to <b>12-17-1875</b> , that I last saw the deceased alive on <b>12-16-1875</b> , and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above. SIGNATURE <b>W. J. Hodges M.D.</b> ADDRESS (Street, city, town, state) <b>123 Flintstone, Allegheny, Pa.</b> DATE SIGNED					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>12-19-1955</b>		NAME OF CEMETERY OR CREMATORIAL <b>Green Meadow Inn</b>	
24. REC'D BY REGISTRAR <b>Dec. 19, 1955</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Bender</b>		LOCATION (City, town, or county) <b>Flintstone, Allegheny, Pa.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Charles J. George, Jr.</b>		ADDRESS <b>123 Flintstone, Allegheny, Pa.</b>			

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11427

## 11415 CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH

COUNTY	Allegany	MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	
TOWN	Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	62 years	
128 Polk St.		

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE	Maryland	COUNTY	Allegany
CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN	Cumberland		
STREET ADDRESS	(If rural give location)		
128 Polk St.			

3. NAME OF  
DECEASED  
(Type or Print)

JOHN E. HERING

(Last)

4. DATE (Month) (Day) (Year)  
OF DEATH Dec. 27, 19555. SEX  
Male6. COLOR OR  
RACE  
White7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify) Single8. DATE OF BIRTH  
Feb. 8, 18939. AGE last birthday  
62 yrsIF UNDER 1 YEAR  
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)  
Plumber10b. KIND OF BUSINESS  
OR INDUSTRY  
Plumbing & Heating11. BIRTHPLACE (State or foreign country)  
Cumberland, Md.12. CITIZEN OF WHAT  
COUNTRY?  
USA

13. FATHER'S NAME

Frederick Hering

14. MOTHER'S MAIDEN NAME

Clara L. Ogle

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) No  
(If Yes, give war or dates of service)16. SOCIAL SECURITY NO  
215-18-8521

17. INFORMANT &amp; ADDRESS

Helen V. Hering, Cumberland, Md.

## 18. MEDICAL CERTIFICATION

1. IMMEDIATE CAUSE (A) *Coronary infarction*  
 ANTECEDENT CAUSE(S) DUE TO  
 DISEASES OR CONDITIONS, IF ANY, (B) \_\_\_\_\_  
 GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST. DUE TO  
 (C) \_\_\_\_\_

INTERVAL BETWEEN  
ONSET AND DEATH  
17 days11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
While at work  Not while  
at work 

21f. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from Dec. 27, 1955, to Dec. 27, 1955, that I last saw the deceased  
alive on Dec. 27, 1955, and that death occurred at 12:20 P.M. from the causes and on the date stated above. 12/27/55

SIGNATURE

R. W. Dravakis, M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)  
Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Dec. 28, 1955 Walter R. Gandy, M.D. William H. Kight, Cumberland, Md.



1 Within corporate limits  
24 hours after death.

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of his death certificate assembly should be detached for use as a burial transit permit.

VS A15C 4-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11428

11416

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY	All	MARYLAND	STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN	Cumberland,	3½ hours	TOWN Cresaptown
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
62 Sacred Heart Hospital		(If rural give location)	
<b>3. NAME OF DECEASED (Type or Print)</b>		<b>4. DATE OF DEATH</b>	
Mary Elizabeth Hershberger		(Month) 12	(Day) 9
(First)	(Middle)	(Year) 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White	Married	Dec. 7, 1873
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
82 yrs.	Housewife	Erie, Pa.	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Samuel McKenzie Alice Winter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
NO	None	Mrs. Thomas Barnes, Cumberland, Md.	
<b>18. MEDICAL CERTIFICATION</b>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Congestive heart failure			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) arteriosclerotic heart disease			
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work	21f. HOW DID INJURY OCCUR?	
<b>22. I hereby certify that I attended the deceased from 12-9-55, 1955, to 12-9-55, 1955, that I last saw the deceased alive on 12-9-55, 1955, and that death occurred at 3 P.M. from the causes and on the date stated above.</b>			
SIGNATURE <i>L. Barnes</i>		ADDRESS (Street, city, town, state) M.D. 57 Breen St. Cumberland, Md.	
DATE SIGNED 12-10-55			
23. BURIAL, CREMATION, REMOVAL—(SPECIFY) Burial	DATE THEREOF Dec. 12, 1955	NAME OF CEMETERY OR CREMATORIAL St. Ambrose Cemetery	LOCATION (City, town, or county) Cresaptown, Md. (State)
24. REC'D BY REGISTRAR Dec. 12, 1955	REGISTRAR'S SIGNATURE <i>Winter L. Barnes, M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles, L. George, Cumberland, Md.	

BUREAU V. S.

DEC 1 1967

RECEIVED

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

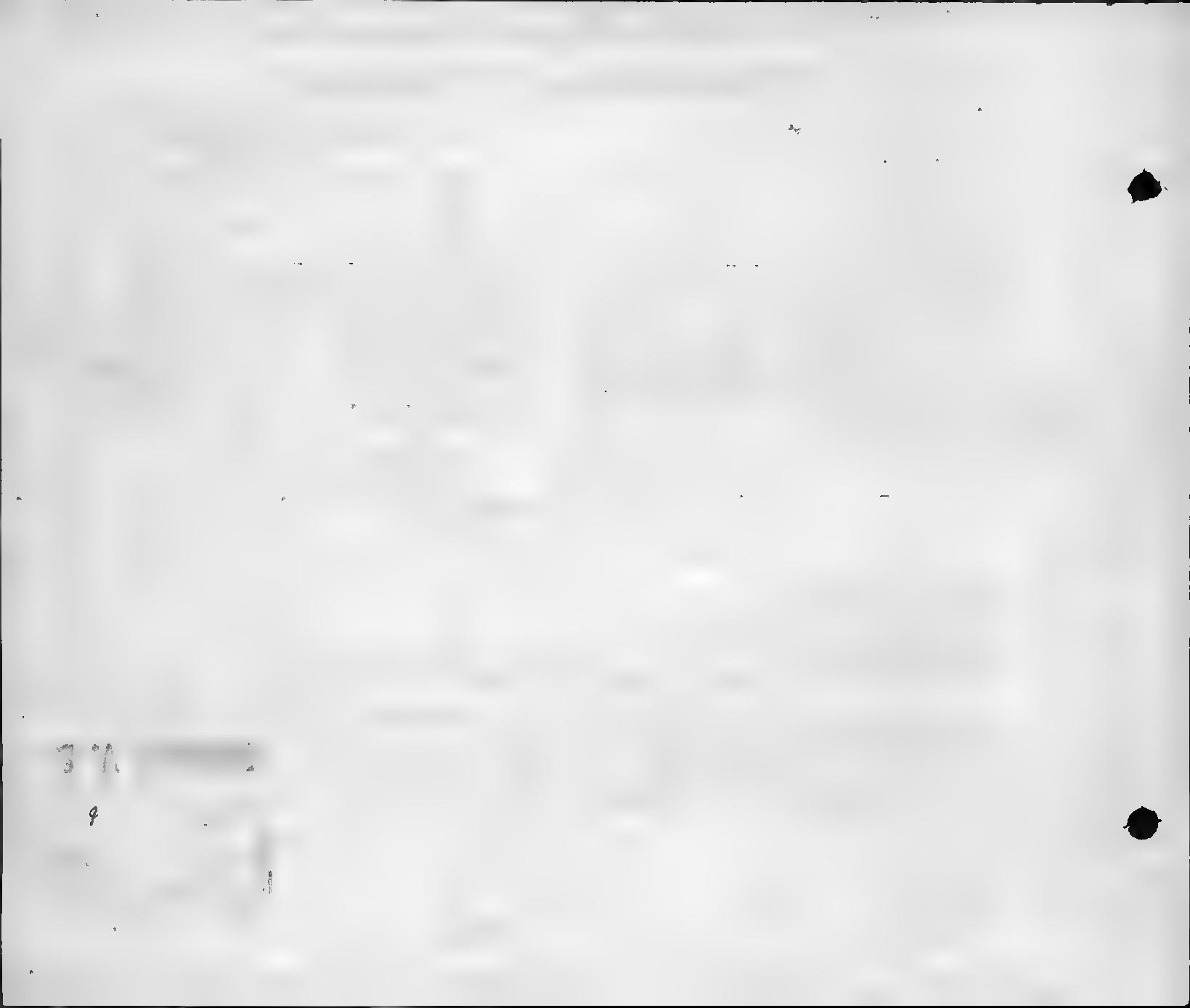
11429

## 11463 CERTIFICATE OF DEATH

Dr. Wilson

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Allegany</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <b>Barton</b>		69 years		TOWN <b>Barton</b>		TOWN <b>Barton</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>70</b>		STREET ADDRESS					
3. NAME OF <b>DECEDENT</b> (First) <b>George</b> (Middle) <b>Harrison</b> (Last) <b>Howell</b>				4. DATE OF DEATH <b>Dec. 26</b> 1955			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb 21 1886</b>	9. AGE last birthday <b>69</b> yrs.	IF UNDER 1 YEAR Months		IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal mine</b>		11. BIRTHPLACE (State or foreign country) <b>Barton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Jefferson Howell</b>				14. MOTHER'S MAIDEN NAME <b>Harriet Moore</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>212-10-7999</b>			
17. INFORMANT & ADDRESS <b>Mrs. GENEVIEVE H. Howell, Barton, Md.</b>				18. MEDICAL CERTIFICATION <b>Chronic Myositis and Myocardial Degeneration Not specified as primary</b>			
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>Holod</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 Years</b>			
IMMEDIATE CAUSE <b>(A) Holod</b>				ANTECEDENT CAUSE(S) <b>(B) DUE TO</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE <b>(C) DUE TO</b>				STATING UNDERLYING CAUSE LAST <b>Chronic Myositis and Asthma</b>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <b>5 Years</b>				21. DATE OF OPERATION <b>None</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>(If either, notify medical examiner)</b>				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <b>None</b>		21c. WHERE DID INJURY OCCUR? (City or town) <b>(County) (State)</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Dec. 26 1955</b>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>None</b>			
22. I hereby certify that I attended the deceased from <b>Apr. 10, 1950</b> to <b>Dec. 26, 1955</b> , that I last saw the deceased alive on <b>Dec. 26, 1955</b> , and that death occurred at <b>7:45A</b> M, from the causes and on the date stated above.							
SIGNATURE <b>Dr. Wilson</b>				ADDRESS (Street, city, town, state) <b>11429</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				DATE SIGNED <b>Dec. 27, 1955</b>			
DATE THEREOF <b>Dec. 29</b>		NAME OF CEMETERY OR CREMATORIAL <b>Philos Cemetery</b>		LOCATION (City, town, or county) <b>Westernport, Md.</b>			
24. REC'D BY REGISTRAR <b>Dr. John C. Kelly</b>		REGISTRAR'S SIGNATURE <b>John C. Kelly</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>E. Boal</b>			
DATE <b>12-29-55</b>				ADDRESS <b>Westernport, Md.</b>			



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-53 10M

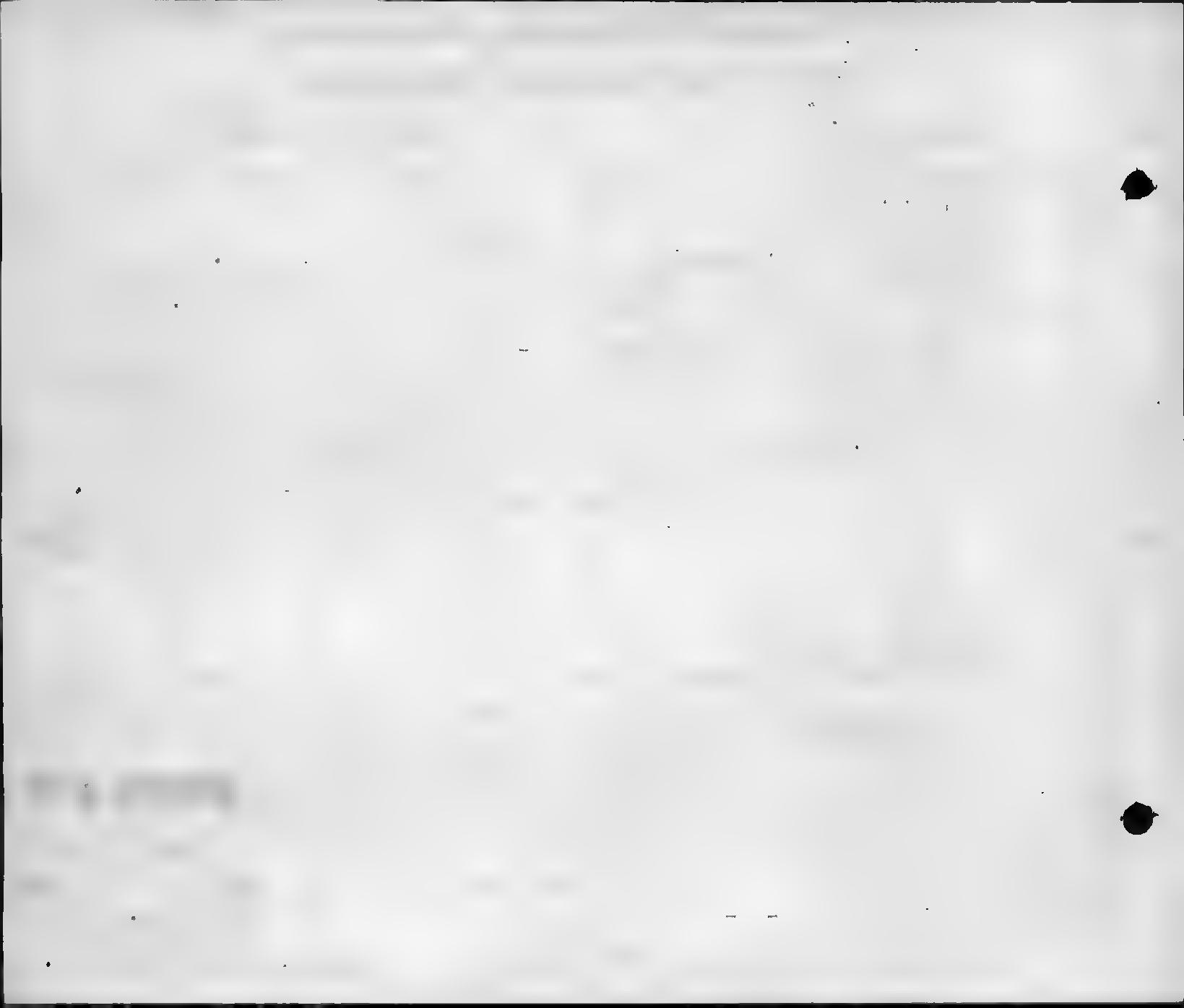
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11430

## 11456 CERTIFICATE OF DEATH

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>								
COUNTY	Allegany	MARYLAND	MARYLAND							
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)								
TOWN	Frostburg	3 days								
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Miners Hospital									
<b>3. NAME OF DECEASED</b> (Type or Print)	(First)	(Middle)	(Last)							
	CHARLOTTE	LOUISE	HUSTON							
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>4. DATE OF DEATH</b>	<b>(Month)</b>	<b>(Day)</b>	<b>(Year)</b>		
female	white	widowed	12-4-1876	79 yrs.	Dec. 21, 1955	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>			10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME Wm. Robison			14. MOTHER'S MAIDEN NAME Rebecca Kirby							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Fred Huston, Frostburg, Md.						
<b>18. MEDICAL CERTIFICATION</b> <i>Cerebral accident ("stroke")</i> <i>Arteriosclerosis (advanced)</i>									INTERVAL BETWEEN ONSET AND DEATH 4 days	
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>										
19a. DATE OF OPERATION 11		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)						
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?						
<b>22. I hereby certify that I attended the deceased from Dec 1, 1955, to Dec 21, 1955, that I last saw the deceased alive on Dec 21, 1955, and that death occurred at 6:30 A.M. from the causes and on the date stated above.</b>									ADDRESS (Street, city, town, state) <i>Frostburg, Md.</i>	DATE SIGNED <i>12/22/55</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-23-55		NAME OF CEMETERY OR CREMATORIAL F'bg. Memorial Park		LOCATION (City, town, or county) Frostburg, Md.			(State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>John B. Davis, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>J. R. Durst, Frostburg, Md.</i>						
DATE 12-23-55		J. R. Durst, Frostburg, Md.								



## 11417 CERTIFICATE OF DEATH

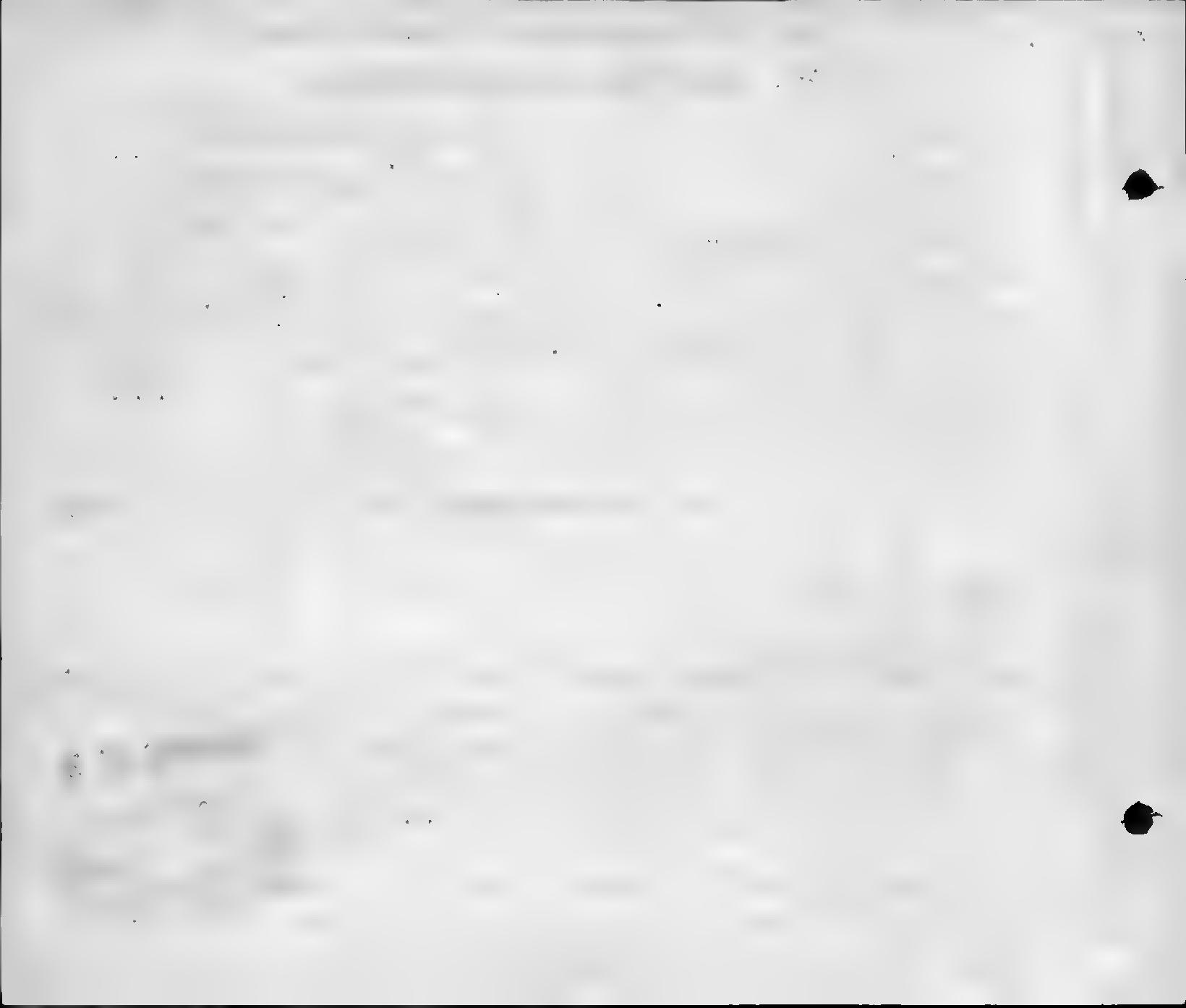
Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	ALLEGANY CUMBERLAND	MARYLAND LENGTH OF STAY (In this place) 2 DAYS	STATE MD. CITY (If outside corporate limits, write RURAL and give nearest town) TOWN FLINTSTONE
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS ROUTE # 2 (If rural give location)		
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)	
4. SEX MALE	5. COLOR OR RACE WHITE	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	7. DATE OF BIRTH NOV. 21, 1877
8. AGE last birthday 78	9. IF UNDER 1 YEAR yrs. Months	10. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME PERRY JAMES		14. MOTHER'S MAIDEN NAME ESTA CUNNINGHAM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none	17. INFORMANT & ADDRESS MEMORIAL HOSPITAL
18. MEDICAL CERTIFICATION <i>Uremia - Congestive heart failure Bileus stenosis Calcific aorta disease</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422-1 IMMEDIATE CAUSE (A)		ONSET AND DEATH 6 wks	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. <input type="checkbox"/> White <input type="checkbox"/> Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from... <i>Dec. 25, 1955</i> to... <i>Dec. 26, 1955</i> , that I last saw the deceased alive on... <i>Dec. 25, 1955</i> , and that death occurred at... <i>10:15 A.M.</i> M, from the causes and on the date stated above. SIGNATURE <i>J. Jerome L. Frazee, Jr.</i> ADDRESS (Street, city, town, state) <i>133 Va Ave, Cumberland, Md.</i> DATE SIGNED <i>12/26/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-26-55	NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Winter F. Frazee, Jr.</i>	LOCATION (City, town, or county) (State) Cumberland, Md.
25. FUNERAL DIRECTOR'S SIGNATURE <i>James E. Scarcelli</i>		ADDRESS <i>Cumberland, Md.</i>	

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## 11434 CERTIFICATE OF DEATH

Reg. Dist. No. 10

## 1. PLACE OF DEATH

COUNTY Allegany  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN Mt Savage, Md.  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS At Hyndman Pa.

MARYLAND  
 LENGTH OF STAY  
 (In this place)

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md.  
 COUNTY Allegany  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 TOWN Mt Savage, Md.  
 STREET  
 ADDRESS (If rural, give location)

## 3. NAME OF

(First)  
 DECEASED  
 (Type or Print)

(Middle)

(Last)

Edward Jenkins

## 4. DATE

(Month)

(Day)

(Year)

Dec 24 1955

## 5. SEX

Male white6. COLOR OR  
 RACE7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED,  
 (Specify) Married

8. DATE OF BIRTH

10a. USUAL OCCUPATION (Give kind of work  
 done during most of working life, even if  
 retired)Labours10b. KIND OF BUSINESS  
 OR INDUSTRYOdd Jobs

11. BIRTHPLACE (State or foreign country)

Mt Savage, Md.12. CITIZEN OF WHAT  
 COUNTRY?U.S.

13. FATHER'S NAME

John W. Jenkins

14. MOTHER'S MAIDEN NAME

Florence Yeager

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.) 210 (If Yes, give war or dates of service) 7/24/55

16. SOCIAL SECURITY NO.

217-10-5825

17. INFORMANT &amp; ADDRESS

Mrs Edward Jenkins - At Hyndman Pa.

18. MEDICAL CERTIFICATION

19a. IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. DUE TO

(C)

19b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE

DISEASE OR CONDITION CAUSING DEATH.

19c. DATE OF OPERATION

19d. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH

(If either, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County) Allegany (State) Md.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

M.  at work  Not white  el work 

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 24 1955 to Dec 24 1955, that I last saw the deceasedalive on Dec 24 1955, and that death occurred at At Hyndman Pa. from the causes and on the date stated above.SIGNATURE John E. Tupper M.D.ADDRESS (Street, city, town, state) Hyndman Pa.DATE SIGNED 12/26/5523. BURIAL, CREMATION,  
 REMOVAL (SPECIFY)BurialDATE THEREOF 12/26/55NAME OF CEMETERY OR CREMATORIUM Mt Savage Meth. Cem.LOCATION (City, town, or county) Mt Savage, Md.(State) Md.

24. REC'D BY REGISTRAR

Veronica M. HermitteREGISTRAR'S SIGNATURE Veronica M. Hermitte25. FUNERAL DIRECTOR'S SIGNATURE John F. HaleADDRESS Cumberland Md.

BUREAU V. S.

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RECEIVED

## INSTRUCTIONS

1. Within 24 hours after death.  
 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 155 10M

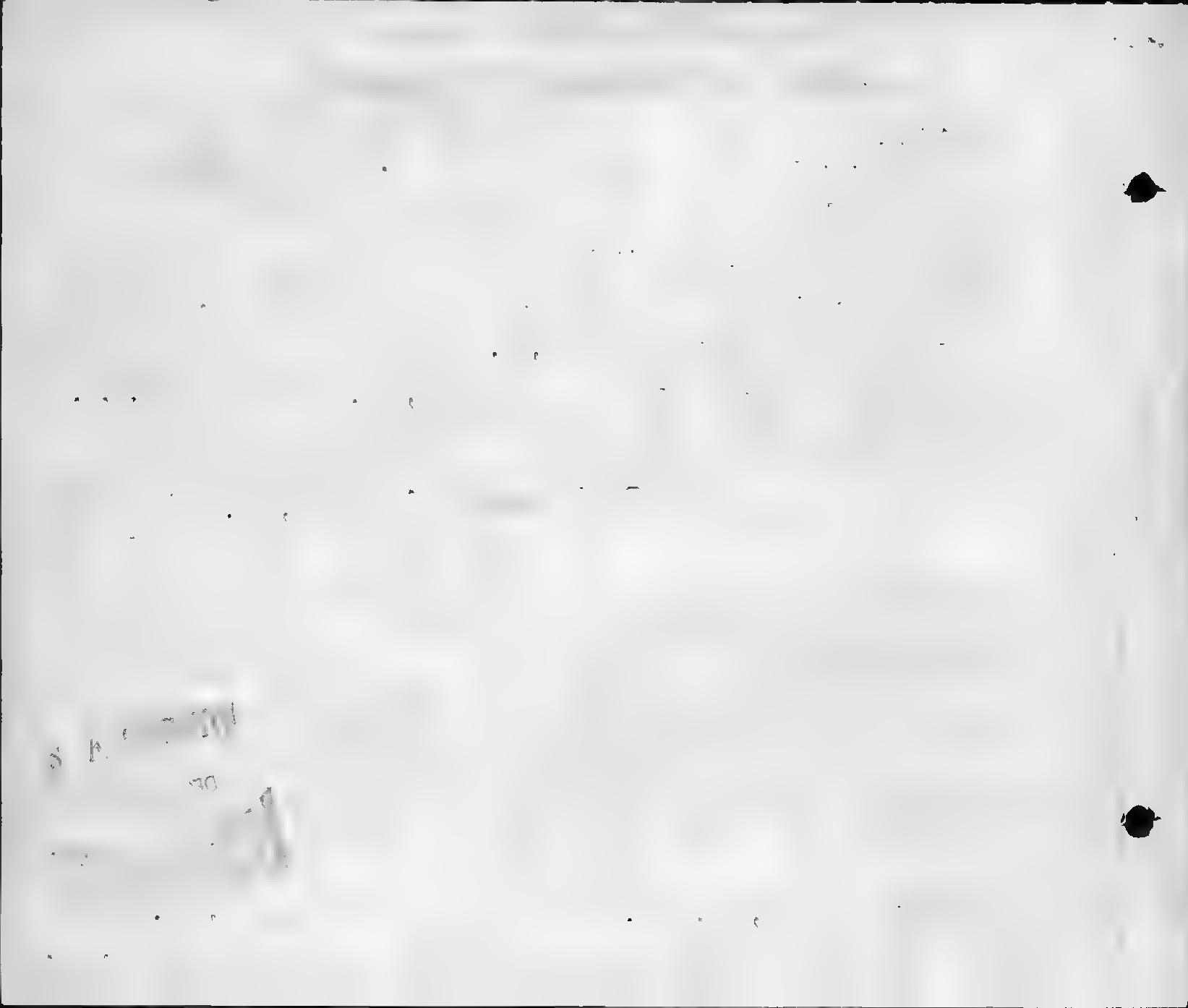
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11433

## 11418 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Allegany Cumberland	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	MD. Allegany Lenacening		
Sacred Heart Hospital		STREET ADDRESS (If rural give location)	
Union Street			
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
Cecelia		Dec, 25 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White	Widowed	Jan, 23. 1889
9. AGE last birthday yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY U.S.A.
66	General Textile Mill	Barten, MD.	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Sherman Crable		Jennie Shonskey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS
No	2160 05-5886		Mrs. Jennie Graham, (DAUGHTER)
18. MEDICAL CERTIFICATION Lenacening, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Myocardial Infarction			
ANTECEDENT CAUSE(S) DUE TO Coronary Occlusion			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C) Arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 24 hr.			
24 hr.			
2 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from July 19, 1955, to Dec. 25, 1955, that I last saw the deceased alive on Dec. 25, 1955, and that death occurred at 8:30 P.M. from the causes and on the date stated above. SIGNATURE George Eichhern, M.D. ADDRESS (Street, city, town, state) 12-27-55 DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Dec, 28. 1955.	NAME OF CEMETERY OR CREMATORIAL Memorial Park	LOCATION (City, town, or county) (State) Frederick, MD.
24. REC'D BY REGISTRAR Dec. 28, 1955	REGISTRAR'S SIGNATURE Walter R. Tracy, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE George Eichhern, Lenacening, MD.	



**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18****11434****11419****CERTIFICATE OF DEATH**Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>Cumberland</u>	
TOWN <u>Cumberland</u>		80 yrs.		TOWN <u>Cumberland</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		840 Maryland, Ave.		840 Maryland, Ave.		1	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Margaret Isabel Judy</u>				<b>4. DATE OF DEATH</b> <u>12/2/55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3/2/1875</u>	9. AGE last birthday <u>80</u>	10. IF UNDER 1 YEAR Months <u></u> Days <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper at Home</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James Keady</u>				14. MOTHER'S MAIDEN NAME <u>Mary Roller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>111-11-1111</u>		17. INFORMANT & ADDRESS <u>Gladys Judy Cumberland, Md.</u>			
18. MEDICAL CERTIFICATION							
<p>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  <u>Arteria obliterata cordis</u> <span style="float: right;">Date to Nov 55</span></p> <p>IMMEDIATE CAUSE (A) <u>Arteria obliterata cordis</u></p> <p>ANTECEDENT CAUSE(S) DUE TO (B) <u>Was ruled disease</u></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u></p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>12/2/55</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) <u>Cumberland, Md.</u> (State) <u>MD</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>10:10 AM</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 2, 1955</u> to <u>12/2/55</u> , that I last saw the deceased alive on <u>Nov. 2, 1955</u> , and that death occurred at <u>10:10 AM</u> , from the causes and on the date stated above. SIGNATURE <u>W. F. Williams</u> ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u> DATE SIGNED <u>12/5/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/2/55</u>		NAME OF CEMETERY OR CREMATORIUM <u>Hillcrest Cemetery</u>		LOCATION (City, town, or county) <u>Cumberland, Md.</u> (State) <u>MD</u>	
24. REC'D BY REGISTRAR <u>Dec. 5, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter F. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joe Silcox</u> ADDRESS <u>Cumberland, Md.</u>			

1955

1955

## INSTRUCTIONS

1. Within corporate limits  
2. Outside corporate limits  
3. Outside corporate limits, write RURAL and give nearest town  
4. Outside corporate limits, write RURAL and give nearest town

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11435

## 11420 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY OR TOWN	Allegheny If outside corporate limits, write RURAL and give nearest town Cumberland, Md.	MARYLAND LENGTH OF STAY (in this place) 4 days	STATE Maryland CITY OR TOWN Jennings, Md. COUNTY Garrett (If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
JOSEPH WILLIAM KEEFE		Dec. 16 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH April 29, 1878
9. AGE last birthday 77 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired m. nager		11. BIRTHPLACE (State or foreign country) Towanda, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Keefe		14. MOTHER'S MAIDEN NAME Sara Schrivins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 312-24-0498	
17. INFORMANT & ADDRESS Mrs Gleaves Knecht, Salisbury, Pa.		18. MEDICAL CERTIFICATION Cerebral Thrombosis Arteriosclerotic Disease	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Cerebral Thrombosis ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Diabetes Mellitus			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov. 16, 1955, to Dec. 16, 1955, that I last saw the deceased alive on Dec. 7, 1955, and that death occurred at 3:10 P.M. from the causes and on the date stated above. SIGNATURE <i>Leonard L. Rock</i> M.D. ADDRESS (Street, city, town, state) <i>209 North St. Meyersdale Pa</i> DATE SIGNED <i>12/17/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/12/55	
NAME OF CEMETERY OR CREMATORIAL Grantsville,		LOCATION (City, town, or county) Grantsville, Garrett Co. Md.	
24. REC'D BY REGISTRAR Dec. 19, 1955		REGISTRAR'S SIGNATURE <i>Walter R. Frank, M.D.</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Ronald J. Newmark</i>		ADDRESS Grantsville, Md.	

030



5000

3000 2000 1000

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

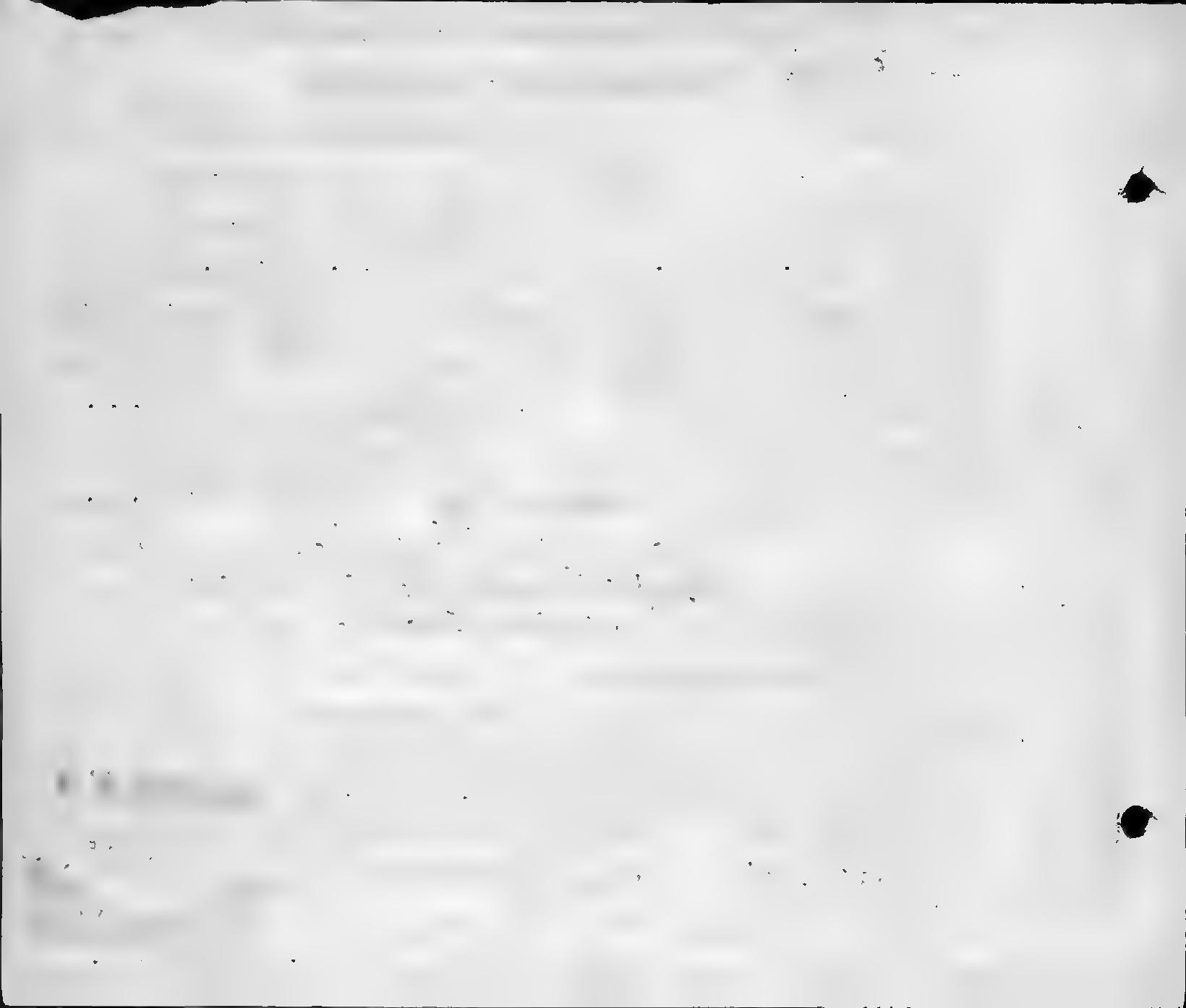
VS AISC 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18** 11436

**11421 CERTIFICATE OF DEATH**

Item 9, Film GL91 1-12-56 et Item 1, Film GL91 1-20-56 et Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Allegany Cumberland	MARYLAND LENGTH OF STAY (in this place) Life	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS
HOSPITAL OR INSTITUTION OR STREET ADDRESS	415 N. Centre St.		Cumberland (If rural give location)
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b>	
(First) Evans Middle Young Last Keller		26 (Year) December 1955	
S. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH I/28/1876
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Louis H Young		14. MOTHER'S MAIDEN NAME Margaret Koegel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Mrs Lloyd Mabus Cumberland, Md.		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH Sudden	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>1120.1 IMMEDIATE CAUSE</b> (A) <i>Coronary Thrombosis</i> ANTECEDENT CAUSE(S) DUE TO <i>Hypertensive Arteric Sclerotic</i> DISEASES OR CONDITIONS, IF ANY, (B) DUE TO <i>Vascular Disease</i> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>12-26-1955</b> to <b>12-26-1955</b> , that I last saw the deceased alive on <b>12-26-1955</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above. SIGNATURE <i>W.L. Stein</i> ADDRESS (Street, city, town, state) <b>Cumberland</b> DATE SIGNED <b>12/28/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 12/29/55	NAME OF CEMETERY OR CREMATORIUM Rose Hill Mausoleum	LOCATION (City, town, or county) Cumberland Maryland
24. REC'D BY REGISTRAR <i>Dec. 29, 1955</i>	REGISTRAR'S SIGNATURE <i>Winter L. Hantz, M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc. Cumberland, Md.	ADDRESS



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this certificate should be detached for use as a burial transit permit.

VS AISC-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

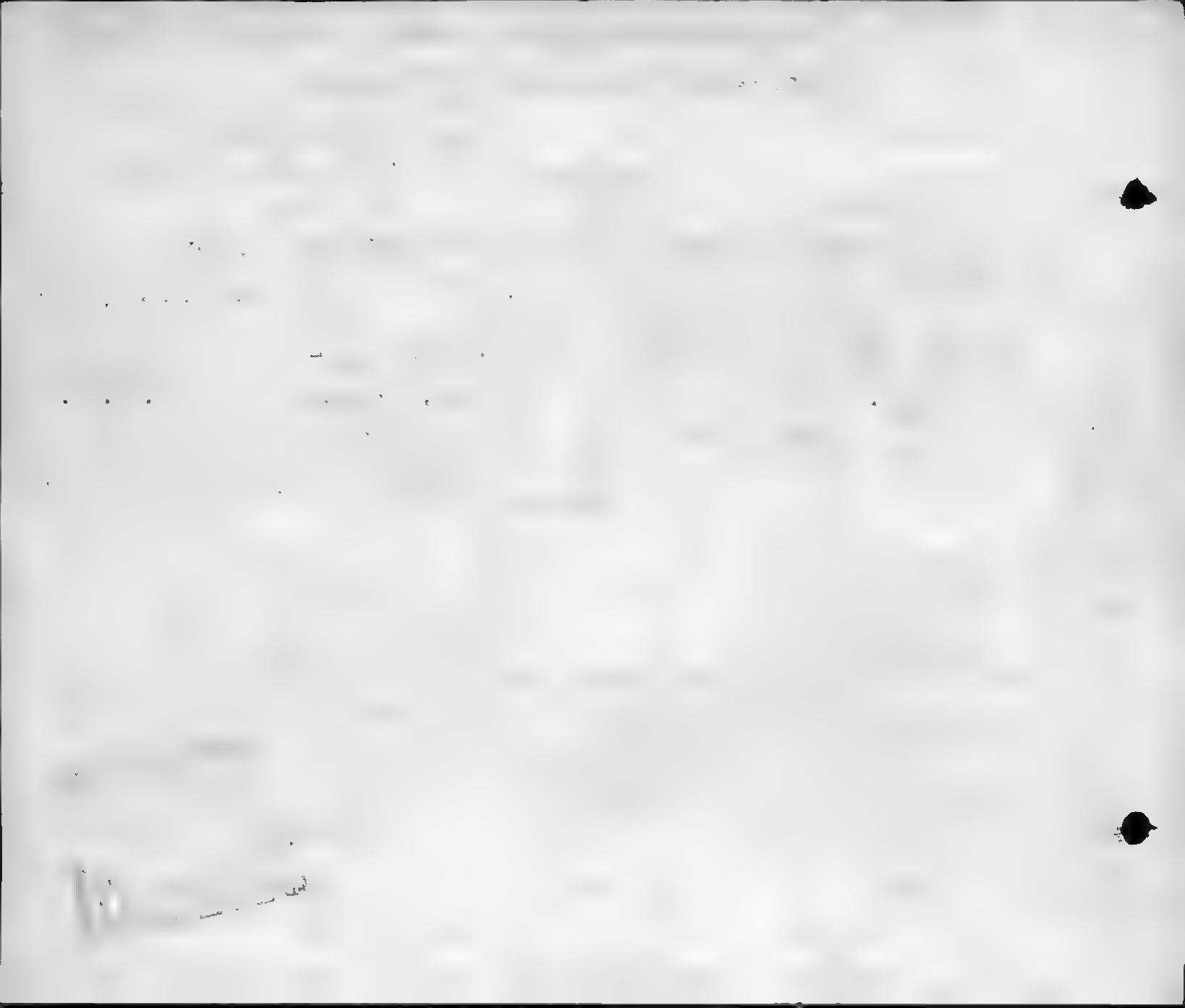
11437

Within corporate limits  
11422

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		ALLEGANY MARYLAND Length of Stay (In this place) 2/23/54		STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		COUNTY Allegany STREET ADDRESS 106 Oak View Drive	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Allegany County Infirmary				43			
3. NAME OF (First) (Middle) (Last) DECEASED (Type or Print) Rosa Fearon Kelly				4. DATE (Month) (Day) (Year) OF DEATH December 8, 1955			
S. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	B. DATE OF BIRTH July 2, 1873	9. AGE last birthday 82	IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None.				11. BIRTHPLACE (State or foreign country) Neury, Ireland			
13. FATHER'S NAME Francis Kelly				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO. None			
17. INFORMANT & ADDRESS Allegany County Infirmary Records				18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO 260X (C)				Berebral Hemorrhage. Chronic Myocardial Degeneration Berebral Arteriosclerosis Diabetes Mellitus.			
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH 18 hrs. ? ? ? ?			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 7, 1954, to Dec 8th, 1955, that I last saw the deceased alive on Dec 7th, 1955, and that death occurred at 10:30 A.M. from the causes and on the date stated above. SIGNATURE Jacqueline S. Lear M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF 12-10-55			
24. REC'D BY REGISTRAR Registrar				NAME OF CEMETERY OR CREMATORIUM St. Gabriel Cemetery			
DATE 12-1-55				LOCATION (City, town, or county) Baltimore Md			
REGISTRAR'S SIGNATURE				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellsworth & Basile Mortuaries			



## 11423 CERTIFICATE OF DEATH

Reg. Dist. No. 4

DR. HODGES

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	ALLEGANY CUMBERLAND	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	MARYLAND CUMBERLAND
LENGTH OF STAY (In this place) 4 DAYS		STREET ADDRESS (If rural give location)	COUNTY ALLEGANY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL		29 MAPLE STREET	
3. NAME OF DECEASED (First) MARTHA (Middle) E. (Last) KIDWELL		4. DATE (Month) (Day) (Year) OF DEATH DECEMBER 15, 1955	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH SEPTEMBER 14 1889
9. AGE last birthday 66 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) PAW PAW, W. VA.
13. FATHER'S NAME CHARLES W. RUDY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unk.)		16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS MEMORIAL HOSPITAL - CUMBERLAND, MD.
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 36 hrs	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		1. IMMEDIATE CAUSE (A) <u>Carcinoma Right breast axilla</u> ANTECEDENT CAUSE(S) DUE TO <u>Circulatory collapse</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Post operative</u> (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 12/17/55	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma R. breast + axill. glands</u>	20. AUTOPSY? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) Cumberland	(County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec 6, 1955</u> to <u>Dec 15, 1955</u> , that I last saw the deceased alive on <u>Dec 15, 1955</u> , and that death occurred at <u>3:20 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>W.R. Hodges</u> ADDRESS (Street, city, town, state) <u>Cumberland, MD</u> DATE SIGNED <u>12/15/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Dec 17, 1955</u>	NAME OF CEMETERY OR CREMATORIAL <u>Woodrow-Union Cemetery</u>	LOCATION (City, town, or county) <u>Woodrow W. Va</u> (State)
24. REC'D BY REGISTRAR <u>Dec. 17, 1955</u>	REGISTRAR'S SIGNATURE <u>Winter R. Frank, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer - Cumberland, MD.</u>	ADDRESS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5 10/M

## INSTRUCTIONS



**INSTRUCTIONS**

Wishes of deceased

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1954-5 10A

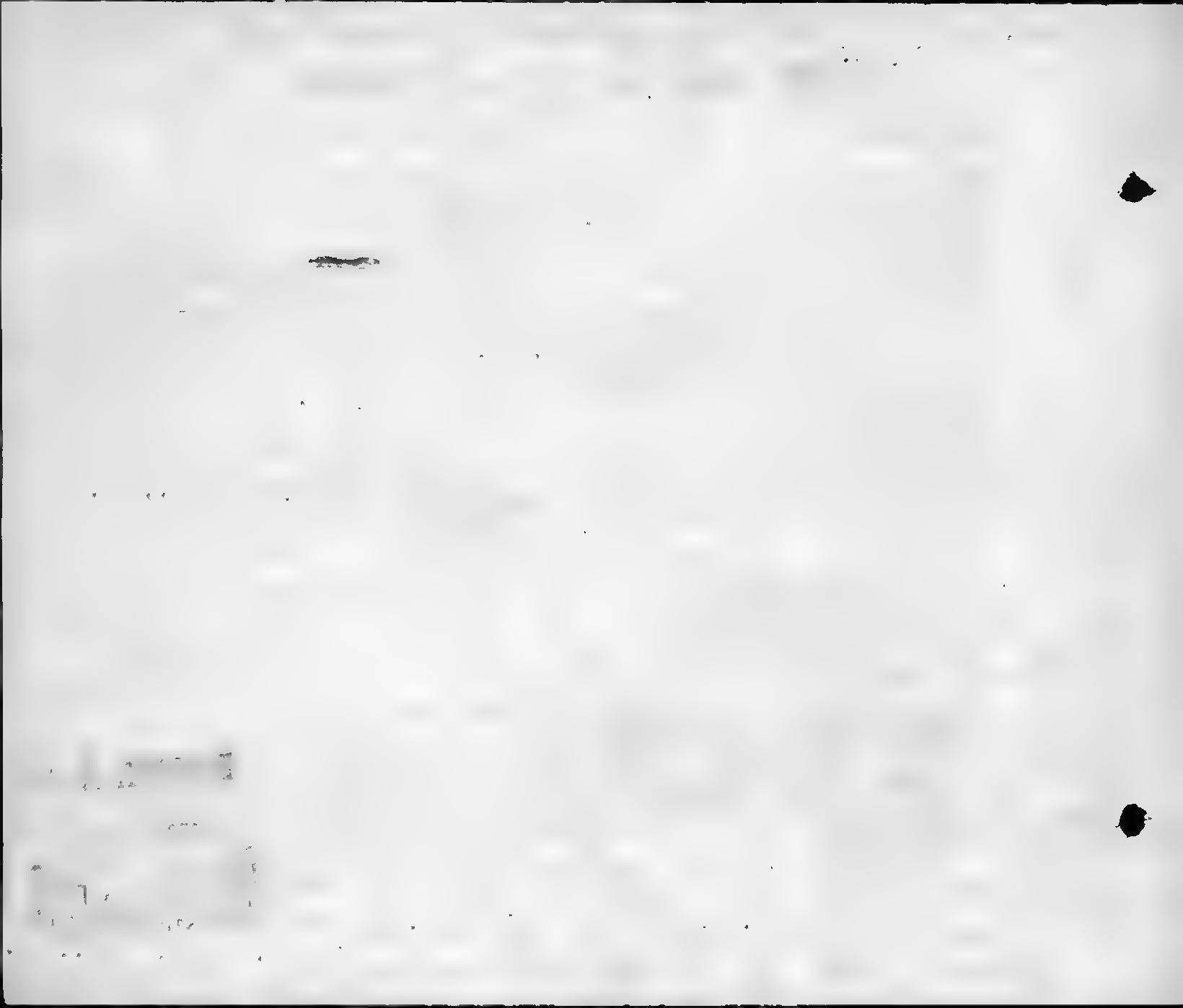
**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

11439

**11424 CERTIFICATE OF DEATH**

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ALLEGANY</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		STREET ADDRESS (If rural give location)	
TOWN <b>22 17 37 110</b>		1 mon. 22 days		TOWN <b>3 17 110</b>		STREET ADDRESS	
<b>62 SACRED HEART HOSPITAL</b>				13. <b>12-7-55</b>			
<b>3. NAME OF DECEASED (Type or Print)</b> <b>Grace Colton Knipp</b>				<b>4. DATE OF DEATH</b> <b>12-7-55</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Nov. 27, 1884</b>	9. AGE last birthday <b>71</b>	IF UNDER 1 YEAR Months <b>0</b> Dey <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Joseph Wilkinson</b>				14. MOTHER'S MAIDEN NAME <b>Hattie Jawkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT & ADDRESS <b>Lester Wilkinson, Cumb., Md.</b>				18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>420.1 IMMEDIATE CAUSE</b> <b>(A) ① Congestive Heart Failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>			
ANTECEDENT CAUSE(S) <b>DUE TO</b> DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <b>(B) ③ Myocardial Infarction, acute</b>				INTERVAL BETWEEN ONSET AND DEATH <b>61 days</b>			
<b>260X</b> II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>(C) ② Pneumonia, Bronchial</b> <b>④ Coronary Sclerosis</b> <b>Dabetes Mellitus + Obesity</b>				INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>			
19a. DATE OF OPERATION <b>19b. MAJOR FINDINGS OF OPERATION</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) <b>1955, to 1 Dec 1955</b>		(County) <b>Cumberland</b> (State) <b>MD</b>	
21d. TIME OF INJURY (Month) <b>Dec.</b> (Day) <b>3</b> (Year) <b>1955</b> (Hour) <b>M.</b>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>7 Oct 1955</b> to <b>1 Dec 1955</b> , that I last saw the deceased alive on <b>30 Nov 1955</b> , and that death occurred at <b>1955</b> M., from the causes and on the date stated above.							
SIGNATURE <b>Janette G. Meade</b> ADDRESS (Street, city, town, state) <b>59 Greene St Cumberland</b> DATE SIGNED <b>1 Dec 56</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Dec. 3, 1955</b>		NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cem.</b>		LOCATION (City, town, or county) <b>Cumberland, Md.</b>	
24. REC'D BY REGISTRAR <b>Dec. 3, 1955</b>		REGISTRAR'S SIGNATURE <b>Walter F. Tracy, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer</b>		ADDRESS <b>John J. Hafer, Cumb., Md.</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

MARGIN PRESERVED FOR BINDING

**PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.**

8° 1.

Sept 25 1977

8° 1.

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be retained by the hospital or attending physician. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

11441

11425

Without corporate limits

**CERTIFICATE OF DEATH**

Reg. Dist. No. 1

**1. PLACE OF DEATH**

COUNTY Allegany

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN Cumberland

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

312 Frederick Street

MARYLAND

LENGTH OF STAY  
(in this place)

35 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Maryland

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Cumberland

STREET  
ADDRESS

312 Frederick Street

COUNTY Allegany

(If rural give location)

**3. NAME OF  
DECEASED  
(Type or Print)**

(First)

(Middle)

(Last)

CHARLES HENRY LEE Jr.

**4. DATE (Month) (Day) (Year)**

December 7 1955

**5. SEX**6. COLOR OR  
RACE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

8. DATE OF BIRTH

9. AGE last birthday

ale

Colored

Married

Dec. 10, 1898

56

yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

laborer

10b. KIND OF BUSINESS  
OR INDUSTRY

Odd Jobs

11. BIRTHPLACE (State or foreign country)

Lynchburg, Virginia

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

**13. FATHER'S NAME**

CHARLES

HENRY

LEE, Sr.

MARY LEFRAGE

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?**

(Yes, no, or unk.) (If Yes, give war or date of service)

Yes

N.Y. 1

**16. SOCIAL SECURITY NO.**

218-30-0563

**17. INFORMANT & ADDRESS**

312 Frederick St.

Mrs. Sally Lee, Cumberland, Md.

**18. MEDICAL CERTIFICATION****I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

492X IMMEDIATE CAUSE

Virus Pneumonia

ANTECEDENT CAUSE(S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,

(B) GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST.

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

9 days.

DISEASES OR CONDITIONS, IF ANY,

(B) GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST.

DUE TO

(C)

INTERVAL BETWEEN  
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(C)

INTERVAL BETWEEN  
ONSET AND DEATH

9 days.

DISEASES OR CONDITIONS, IF ANY,

(B) GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING

2011.3.19.81

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**INSTRUCTIONS**1. **ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AUSC 1-5 10M

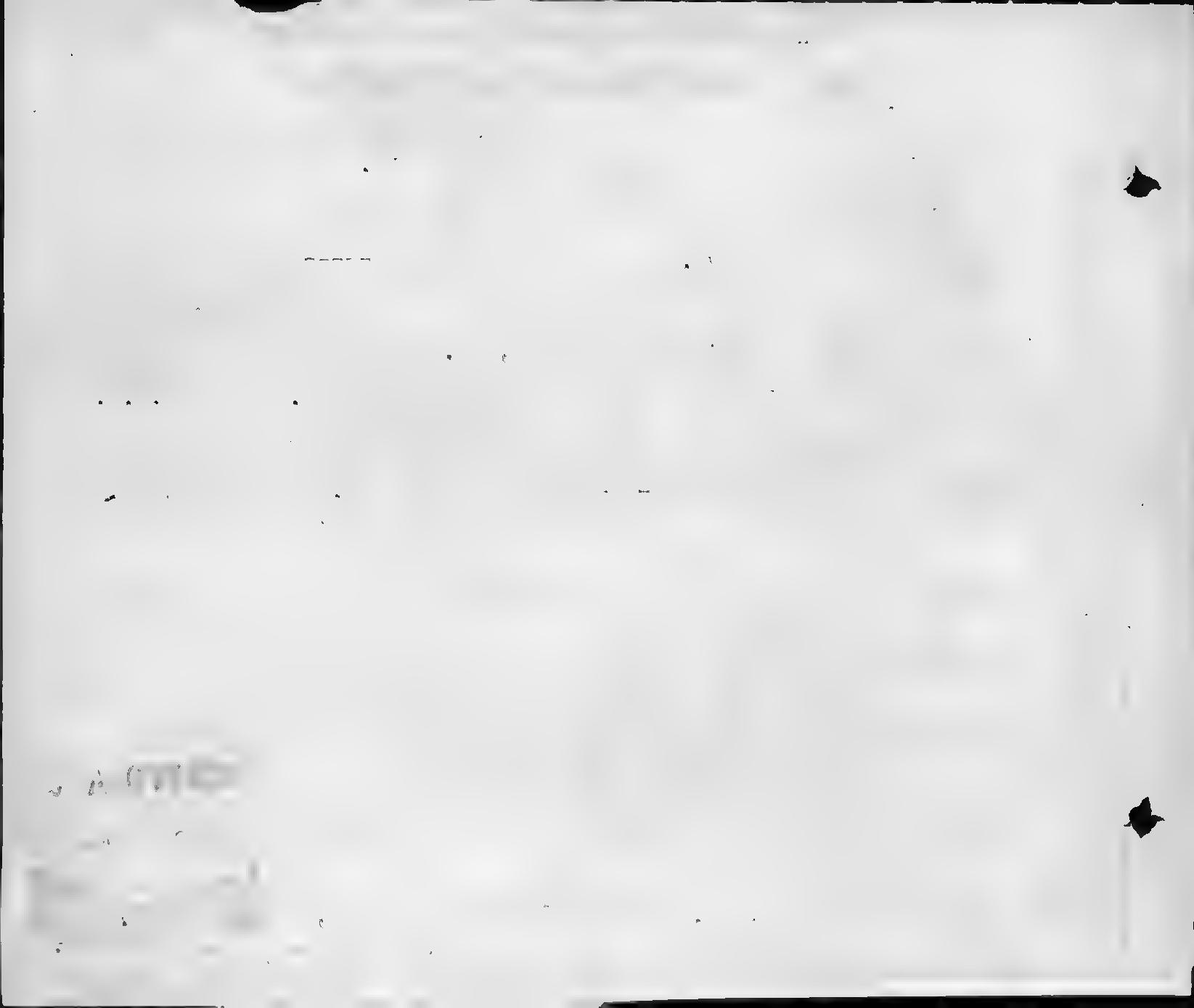
**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

11442

**11426 CERTIFICATE OF DEATH**

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Allegany	MARYLAND	STATE
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Length of Stay (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	MD.
TOWN	Cumberland	TOWN	Allegany
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS		
Cleveland Ave.			
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) THOMAS		(Middle) LEE	
(Last)		5. SEX Male	
6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	
8. DATE OF BIRTH April, 12, 1877		9. AGE last birthday 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
11. BIRTHPLACE (State or foreign country) Westernport, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Lee		14. MOTHER'S MAIDEN NAME Ellen Foley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 179-03-4997	
17. INFORMANT & ADDRESS Henry Lee, Cumberland, MD.		18. MEDICAL CERTIFICATION (SON)  Hypertensive arterio-sclerotic vascular disease.	
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH One year.	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. DATE OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12-25-1955 to 12-25-1955, that I last saw the deceased alive on 12-25-1955, and that death occurred at 9a.m., from the causes and on the date stated above. SIGNATURE W.L. Williams ADDRESS (Street, city, town, state) Cumberland Alleg. 12-27-55 DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec, 28, 1955 NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cemetery, Moscow	
24. REC'D BY REGISTRAR Dec. 28, 1955		REGISTRAR'S SIGNATURE Walter R. Bantz, M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lenacoming, MD.		ADDRESS	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

## 1. PLACE OF DEATH:

COUNTY Allegany MARYLAND  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN Cumberland LENGTH OF STAY  
 (In this place)  
 3 days

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS Memorial Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany  
 CITY (If outside corporate limits write RURAL and give nearest town)  
 OR  
 TOWN Cumberland STREET ADDRESS  
 (If rural, give location)  
 819 Frederick St.

3. NAME OF (First) (Middle) (Last)  
 DECEASED: (Type or Print) Mary Ellen Loy

4. DATE (Month) (Day) (Year)  
 OF DEATH Dec. 31 1955

5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE OF BIRTH:  
 RACE: WIDOWED, DIVORCED,  
 Female white widow Nov. 27-1923 72

9. AGE last birthday: IF UNDER 1 YEAR  
 yrs. Months Days Hours Min.  
 12. CITIZEN OF WHAT  
 COUNTRY? U.S.A.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY:  
 widow Own Home Ellerslie, Md.

11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT  
 COUNTRY? U.S.A.

13. FATHER'S NAME: Lemmert Wilger

14. MOTHER'S MARRIED NAME: Sophia Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.: 17. INFORMANT & ADDRESS:  
 (Yes, no, or unk.) (If Yes, give war or dates of service) none Memorial Hospital records.

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Probable cerebral hemorrhage due to hypertension. 3 days  
 Immediate cause (a) DUE TO

Probable cerebral hemorrhage due to a  
 probable fractured skull, fell to floor.

Diseases or conditions, if any, (b) DUE TO  
 giving rise to the above cause  
 stating underlying cause last (c) also had a cardio-vascular disease.

11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

Autopsy refused by family. 20. AUTOPSY?  
 Yes  No

21a. EXTERNAL CAUSE WAS PRIMARY  or CONTRIBUTING  CAUSE OF DEATH. 21b. PLACE (Home, farm, factory, of street, office bldg., etc.) INJURY One 21c. (City or town) (County) (State)  
 Cumberland Allegany Md.

21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED OF INJURY Dec. 29-1955 P.M. While at Not while work at work

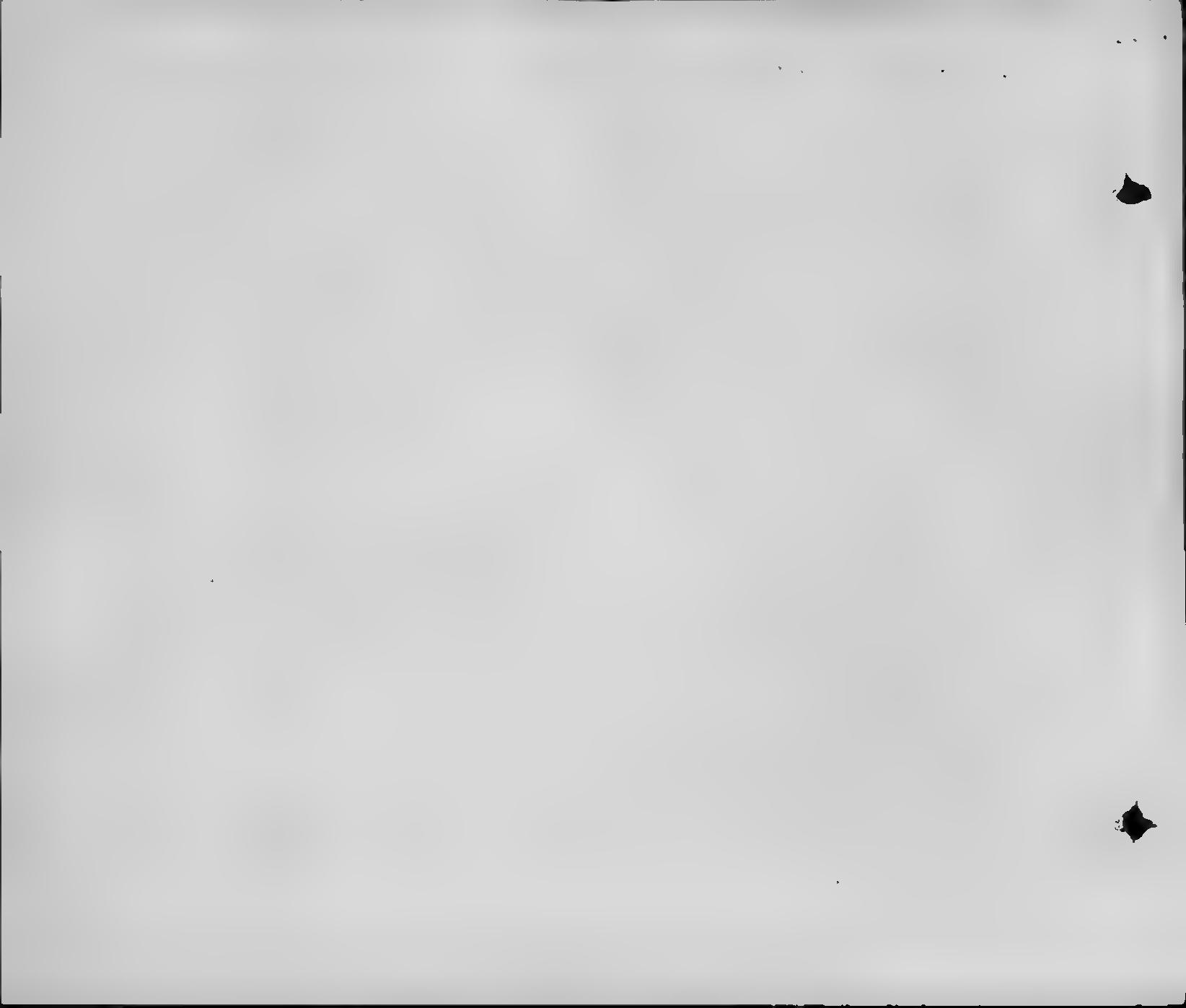
21f. HOW DID INJURY OCCUR? Dizzy, fell to the floor, striking on left side of face.

22. I hereby certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and find that death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined cause   
 SIGNATURE

CHIEF MEDICAL EXAMINER  
 DEPUTY MEDICAL EXAMINER  
 ASSISTANT MEDICAL EXAM DATE SIGNED  
 Dec. 31-1955

23. BURIAL, CREMATION, REMOVAL (Specify): DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)  
 Burial Dec. 2, 1956 Beaumont Cemetery Cumberland, Maryland

DATE REC'D BY LOCAL REG. DATE REC'D BY LOCAL REG. 24. FUNERAL DIRECTOR ADDRESS  
 Dec. 4, 1955 Walter L. Hantz, M.D. John J. Taylor, " "



11444

**11428 CERTIFICATE OF DEATH**

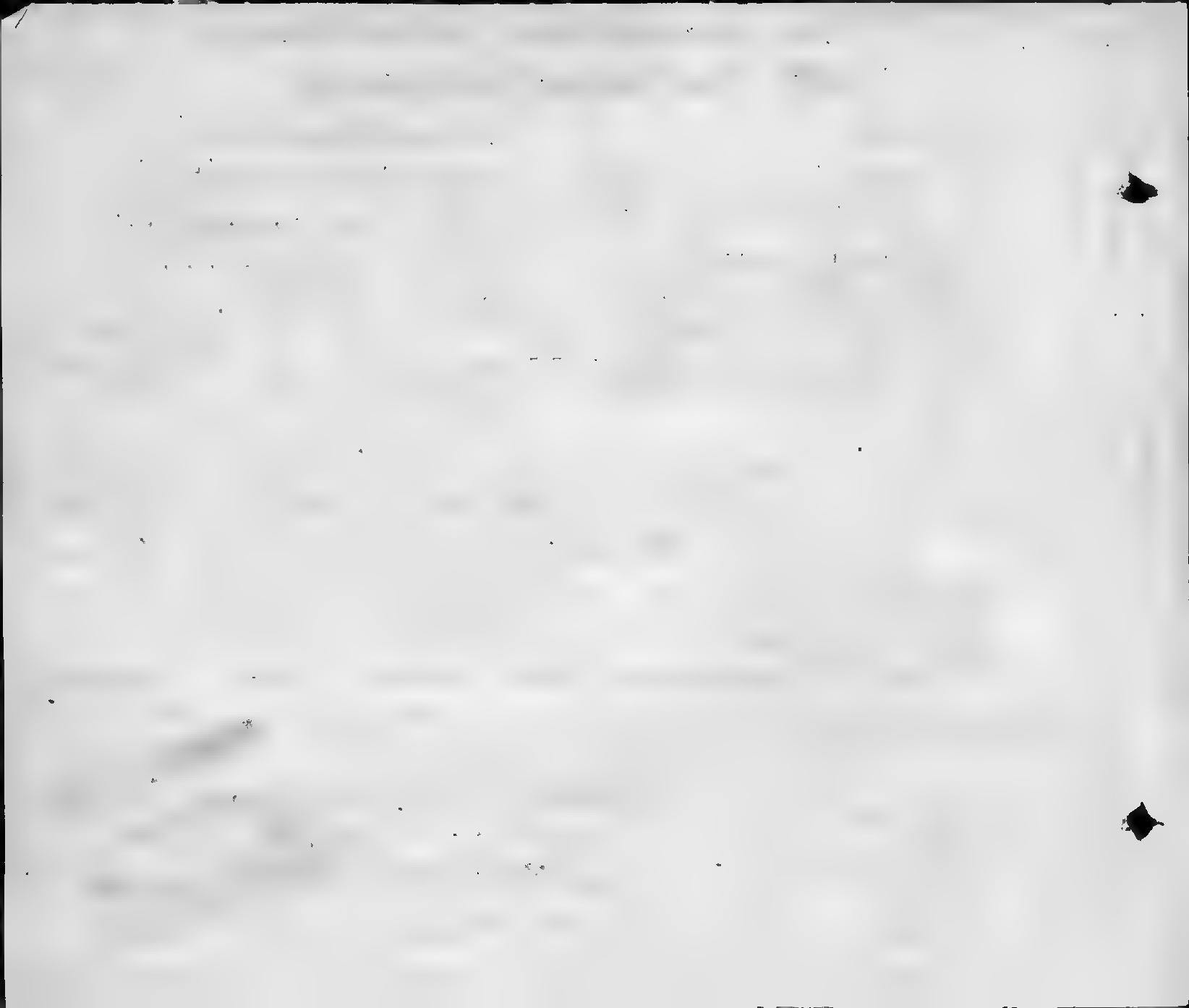
Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>ALLEGANY</b> CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <b>CUMBERLAND</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>		STATE <b>MARYLAND</b> COUNTY <b>ALLEGANY</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>CUMBERLAND, MD.</b> RURAL STREET ADDRESS <b>POTOMAC PARK, R.F.D. #6,</b>	
3. NAME OF DECEASED (Type or Print) <b>VICKIE</b>		4. DATE OF DEATH <b>DEC. 26 1955</b>	
(First) <b>L</b> (Middle)		(Last) <b>MACKERETH</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>7-5-55</b>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	9. AGE last birthday YRS. <b>5</b> MONTHS <b>21</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>
13. FATHER'S NAME <b>CHESTER W. MACKERETH</b>		14. MOTHER'S MAIDEN NAME <b>GLORIA E. MEYERS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>111-11-1111</b>	17. INFORMANT & ADDRESS <b>MEMORIAL HOSPITAL</b>
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <b>Pneumonia</b> ANTECEDENT CAUSE(S) DUE TO (B) <b></b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) STATING UNDERLYING CAUSE LAST, DUE TO (D) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <b>1955</b>		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <b>1955</b> 12-29-55		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>25 Dec 1955</b> , 1955, to <b>26 Dec 1955</b> , 1955, that I last saw the deceased alive on <b>26 Dec 1955</b> , 1955, and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above. SIGNATURE <b>Thomas Robinson</b> ADDRESS (Street, city, town, state) <b>M.D. 1325 Liberty St. Cumberland, Md.</b> DATE SIGNED <b>27 Dec 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>12-29-55</b>	NAME OF CEMETERY OR CREMATORIAL <b>Davis Memorial</b> LOCATION (City, town, or county) (State) <b>Cumberland, Md. (State)</b>
24. REC'D BY REGISTRAR <b>Dec 28 1955</b>		REGISTRAR'S SIGNATURE <b>Walter F. Bantz, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b> ADDRESS

**TO ATTENDING PHYSICIAN OR HOSPITAL** The law requires that  
The bottom copy may be retained by the hospital or attending physician.

The bottom copy may be retained by the hospital or attending physician.

A15C 1-55 1084



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been **executed** by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-51 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11445

## 11457 CERTIFICATE OF DEATH

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>					
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (In this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		COUNTY Allegany			
Allegany Frostburg,		11 days		Maryland Frostburg		Allegany			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital				STREET ADDRESS 66 Broadway					
<b>3. NAME OF DECEASED</b> (First) Mary (Middle) Jane (Last) MacMannis				<b>4. DATE OF DEATH</b> Dec. 10th, 1955					
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH April 13th, 1871			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) England			
13. FATHER'S NAME Christopher Roberts				14. MOTHER'S MAIDEN NAME Jane Boynes					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS None					
<b>18. MEDICAL CERTIFICATION</b>									
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (A) <i>Arteriosclerotic Heart Disease, mild.</i>				several days					
ANTECEDENT CAUSE(S) DUE TO (B) <i>age. &amp; Hypertensive Heart Disease</i>				Yrs -					
DISEASES OR CONDITIONS, IF ANY, (C) GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST.									
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)				(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Jan. 1950, to Dec. 10, 1955, that I last saw the deceased alive on Dec. 10, 1955, and that death occurred at 10:30 A.M. from the causes and on the date stated above.								ADDRESS (Street, city, town, state) Frostburg, Md. DATE SIGNED 12/10/55	
SIGNATURE John B. Davis, M.D.									
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-13-55		NAME OF CEMETERY OR CREMATORIAL F'bg. Memorial Park		LOCATION (City, town, or county) Frostburg, Md.		(State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Dorothy N. Rose		25. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		ADDRESS			
DATE 12-13-55									

REGISTRY  
BUREAU V.

DEC 20

## 11429 CERTIFICATE OF DEATH

Reg. Dist. No. 4

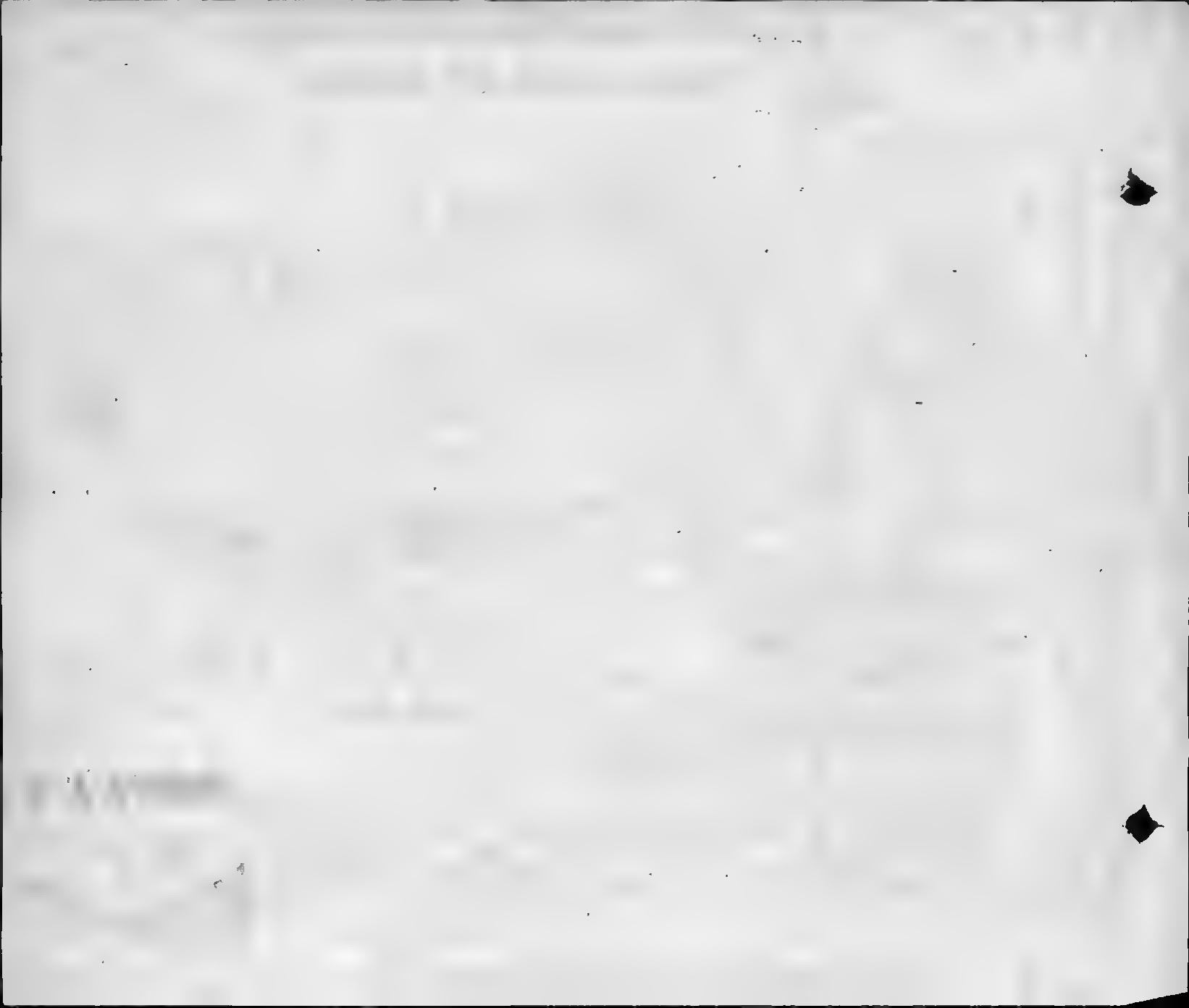
## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED					
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Allegany Cumberland	MARYLAND LENGTH OF STAY (In this place) 70 Years	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Maryland Cumberland	COUNTY Allegany		
HOSPITAL OR INSTITUTION OR STREET ADDRESS	414. Park Street		STREET ADDRESS	(If rural give location) 414. Park Street			
3. NAME OF DECEASED (Type or Print)	(First) Thomas	(Middle) James	(Last) Ma lamphy	4. DATE OF DEATH	(Month) Dec	(Day) 21	(Year) 1955
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	February 25 1885	70	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA.		
Live stock dealer		Buying & selling	Cumberland, Maryland				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Michael Ma lamphy		Elizabeth Stanton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		213-22-3498		Mrs. Blanche Ma lamphy, Cumberland, Md.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Chronic Bronchitis and Bronchietasis, Ten years							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, (B) giving rise to the above cause STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
Chronic Myocarditis, 3 years							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		19c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. HOW DID INJURY OCCUR?			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. ADDRESS (Street, city, town, state)			
22. I hereby certify that I attended the deceased from ..... 1952, to 12-26, 1955, that I last saw the deceased alive on 11-26, 1955, and that death occurred at 10 A.M. from the causes and on the date stated above. SIGNATURE: <i>J. J. Johnson Jr.</i> M.D. ADDRESS: <i>Cumberland, Md.</i> DATE SIGNED: <i>11-26-55</i>							
23. BURIAL, CREMATION REMOVAL (SPECIFY) Burial		DATE THEREOF Dec 23 1955		NAME OF CEMETERY OR CREMATORIUM St. Patricks Cemetery		LOCATION (City, town, or county) Cumberland, Md. (State)	
24. REC'D BY REGISTRAR DATE 11-22-1955		REGISTRAR'S SIGNATURE Walter L. Grant, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE John Wright		ADDRESS Cumberland, Md.	



## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11430

## CERTIFICATE OF DEATH

11447

Reg. Dist. No. 4

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Allegany		MARYLAND	STATE Maryland		COUNTY Allegany
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN Cumberland		35 yrs	TOWN Cumberland		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 46 Marion			STREET ADDRESS 46 Marion Street		
3. NAME OF DECEASED (Type or Print) Francis Charles Mamajek			4. DATE OF DEATH Dec. 2 1955		
5. SEX M	6. COLOR OR RACE FF	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9/24/1897	9. AGE last birthday 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker			10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad	11. BIRTHPLACE (State or foreign country) Pittsburgh, Pa.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles Mamajek			14. MOTHER'S M AIDEN NAME Mary Zera		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No			16. SOCIAL SECURITY NO. 705-05-4512		
17. INFORMANT & ADDRESS Cumberland, Md.			18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
1. IMMEDIATE CAUSE (A) Carcinomatosis			2 mo		
ANTECEDENT CAUSE(S) DUE TO					
DISEASES OR CONDITIONS, IF ANY, (B) Carcinoma Rectum					
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO					
(C) Carcinoma Rectum			1 yr.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION Feb. 1955			19b. MAJOR FINDINGS OF OPERATION abdominal carcinoma Rectum & metastasis		
19c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Feb. 9, 1955, to Dec. 2, 1955, that I last saw the deceased alive on Dec. 1, 1955, and that death occurred at 7:30 P.M. from the causes and on the date stated above. SIGNATURE: C. Mamajek M.D.					
23. BURIAL, Cremation, REMOVAL (SPECIFY) Burial			ADDRESS (Street, city, town, state) Cumberland, Md. DATE SIGNED 12-7-55		
DATE THEREOF 12/5/55			NAME OF CEMETERY OR CREMATORI St. Peters & Pauls		
LOCATION (City, town, or county) Cumberland, Md.			(State)		
24. REC'D BY REGISTRAR Dec. 5, 1955			REGISTRAR'S SIGNATURE Wm. R. Tracy, M.D.		
25. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox			ADDRESS Cumberland, Md.		



## INSTRUCTIONS

1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11431 CERTIFICATE OF DEATH

11448

Reg. Dist. No. 1

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY		Allegany		MARYLAND		STATE Maryland		
CITY (If outside corporate limits, write RURAL OR and give nearest town)		TOWN Cumberland		LENGTH OF STAY (In this place)		COUNTY Allegany		
				4yr. 11mo.		CITY (If outside corporate limits, write RURAL and give nearest town)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Sylvan Retreat		STREET ADDRESS		TOWN Cumberland		
						(If rural give location)		
				5 Grand Ave.				
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)				
(First)		(Middle)		(Last)		December 27, 1955		
Flossie		Myrtle		Manges				
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F	W	Separated	September 25, 1882	73	Months	Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		
Housewife			Own Home			Hyndman, Penn.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				
John Evans				Elizabeth (Unknown)				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.			17. INFORMANT & ADDRESS		
No			None			John Manges, 16 Arch St. Cumb. (son)		
18. MEDICAL CERTIFICATION								
<p>IMMEDIATE CAUSE (A) <i>Pulmonary Hypostasis</i></p> <p>ANTECEDENT CAUSE(S) DUE TO (B) <i>Chronic Myocarditis</i></p> <p>DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <i>Osteo-arthritis</i></p> <p>STATING UNDERLYING CAUSE LAST. (C) <i>Undiagnosed psychosis</i></p>								
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Dec 27, 1955</i> 19 to <i>Dec 27, 1955</i> , that I last saw the deceased alive on <i>Dec 27, 1955</i> , and that death occurred at <i>8:20 PM</i> , from the causes and on the date stated above. SIGNATURE <i>James E. McLean M.D.</i> ADDRESS <i>49 Greene St.</i> DATE SIGNED <i>12-28-55</i>								
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county) (State)		
Burial		Dec 30, 1955		Hyndman Cemetery		Hyndman, Pennsylvania.		
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		
<i>Dec 29, 1955</i>		<i>Walter A. Gandy, M.D.</i>		<i>James F. Scarpelli</i>		Cumberland, Maryland.		

915

## INSTRUCTIONS

Outside of  
City  
limits  
after  
hours

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after the death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. The certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

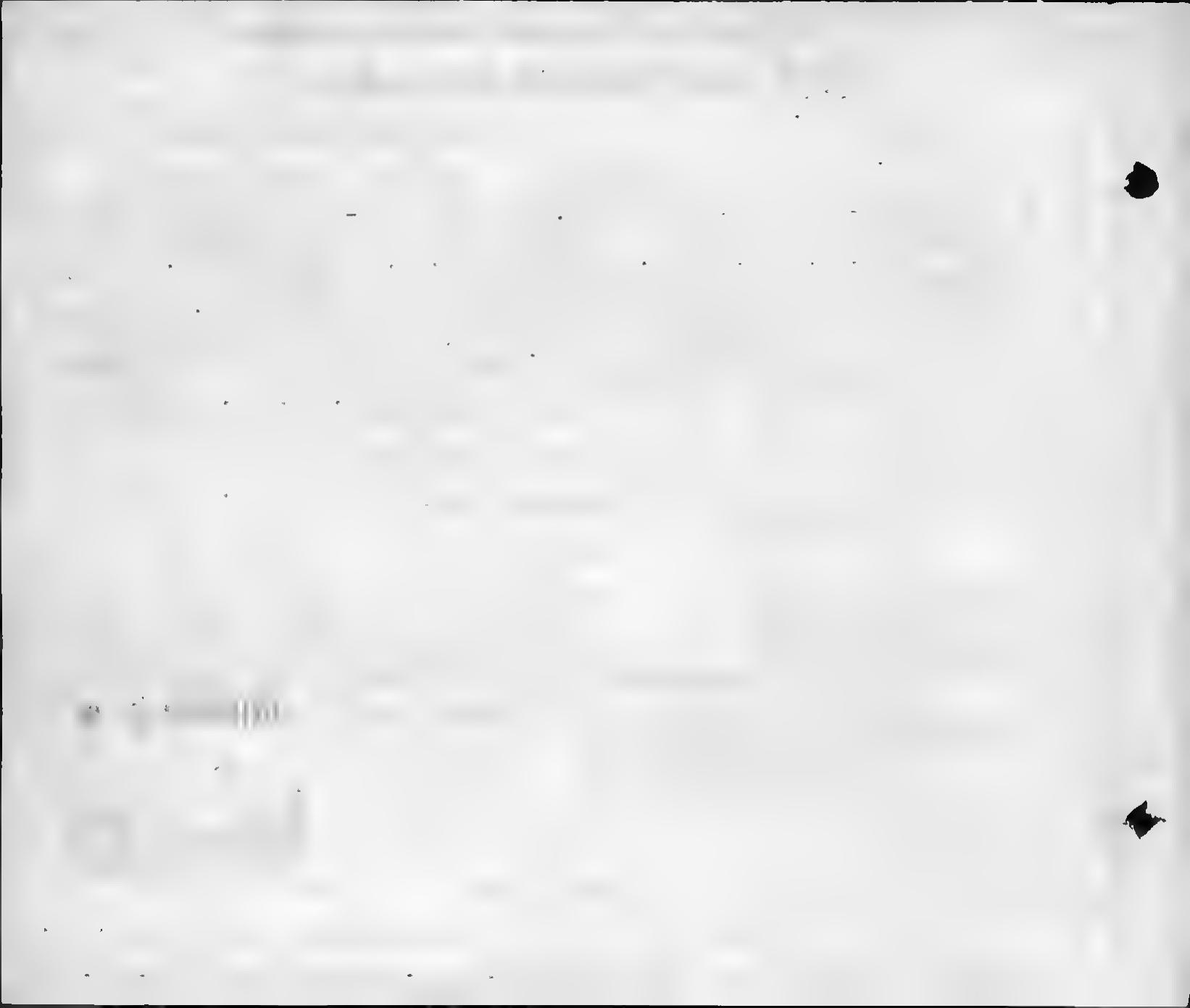
11449

11466

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Allegany		MARYLAND	STATE Maryland		COUNTY Allegany
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN Rural-Cumberland		10 yrs.	TOWN Rural-Cumberland		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location)		
Rt. 4, Oldtown Rd. Cumberland Lt. 4.			Oldtown Road		
3. NAME OF DECEASED (Type or Print)			4. DATE (Month) (Day) (Year)		
Verdie Ellen McBride			Dec. 18 1955		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR Months Days Hours Min.
F	W		Oct. 16, 1868	87 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		
			11. BIRTHPLACE (State or foreign country) Hampshire Co., W. Va.		
13. FATHER'S NAME Abraham Barnes			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
			14. MOTHER'S MAIDEN NAME Maggie Bowman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.)			16. SOCIAL SECURITY NO. None		
			17. INFORMANT & ADDRESS George McBride, Rt. 4, Cumberland		
18. MEDICAL CERTIFICATION					
19. I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Semile Caralis - Vascular Disease and Malignancy ANTECEDENT CAUSE(S) DUE TO (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH Unknown					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Miss in left lower quadrant Unknown					
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 15 Dec., 1955, to 19 Dec., 1955, that I last saw the deceased alive on 15 Dec., 1955, and that death occurred at 4:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city, town, state) 232 Baltimore Av. DATE SIGNED 12-19-55 Carlton Brinsford M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/20/55		NAME OF CEMETERY OR CREMATORIAL Baptist Cemetery	
24. REC'D BY REGISTRAR Dec. 21, 1955		REGISTRAR'S SIGNATURE Walter R. Frank M.D.		LOCATION (City, town, or county) Three Churches, W. Va.	
				25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.	



**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After the registrar within 72 hours, after death. After the funeral director, the third copy of the bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10A

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18****11432 CERTIFICATE OF DEATH**

11450

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		ALLEGANY CUMBERLAND, MEMORIAL HOSPITAL MEMORIAL AVE.		MARYLAND LENGTH OF STAY (In this place) 24 DAYS		STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET ADDRESS RT. #5, Jockey Road, rural ALLEGANY	
<b>3. NAME OF DECEASED (Type or Print)</b> <b>MRS ELIZABETH</b>				<b>4. DATE OF DEATH</b> <b>DEC. 22 1955</b>			
S. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>JULY 19 1869</b>	9. AGE at birthday <b>86</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>
13. FATHER'S NAME <b>JOHN HAINES</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <b>No</b>				16. SOCIAL SECURITY NO. <b>Not</b>			
17. INFORMANT & ADDRESS <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>				18. MEDICAL CERTIFICATION <b>Pulmonary Embolism</b>			
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>464x IMMEDIATE CAUSE</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <b>(A) Peripheral Vascular Disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Chronic Arterio Sclerotic Cardio Vascular Disease</b>				22. HOW DID INJURY OCCUR? <b>falls</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		23. WHERE DID INJURY OCCUR? (City or town) <b>Hyndman, Md.</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		(County) <b>Hyndman</b> (State) <b>MD</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		24. DATE SIGNED <b>12/24/55</b>			
22. I hereby certify that I attended the deceased from <b>Nov. 1, 1955</b> to <b>Dec. 22, 1955</b> , that I last saw the deceased alive on <b>Dec. 22, 1955</b> , and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above. <b>SIGNATURE</b> <i>John G. Lopper</i> <b>ADDRESS</b> (Street, city, town, state) <i>Hyndman, Md.</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Dec. 26, 1955</b>		NAME OF CEMETERY OR CREMATORIAL <b>Mt. Pleasant Meth. Cemetery, Rural - Near Cumberland, Md.</b>		LOCATION (City, town, or county) (State) <b>Hyndman, Md.</b>	
24. REC'D BY REGISTRAR <b>Dec. 26, 1955</b>		REGISTRAR'S SIGNATURE <b>Walter R. Frantz, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Md.</b>		ADDRESS	

11/11/1961

DEC

1961

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the third copy of the certificate has been executed by the physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11451

## 11433 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY <b>ALLEGANY</b>		MARYLAND		STATE <b>MARYLAND</b> COUNTY <b>ALLEGANY</b>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <b>Cumberland</b>		15 days		TOWN <b>Cumberland</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Sacred Heart Hospital		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <b>Naomi Meade</b>		(First) (Middle) (Last)		4. DATE OF DEATH <b>12-23-1955</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>2-3-67</b>	9. AGE last birthday <b>48</b>	IF UNDER 1 YEAR <b>0 months 0 days</b> IF UNDER 24 HRS. <b>0 hours 0 min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own House</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland Cumberland</b>	
13. FATHER'S NAME <b>Robert Parker</b>		14. MOTHER'S MAIDEN NAME <b>Stella Weadon</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>Carl Meade Cumberland, Md.</b>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE <b>pulmonary embolism</b> (A) DUE TO <b>after cholecystectomy and diagnosis for</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b>					
ANTECEDENT CAUSE(S) <b>empyema of gallbladder</b> (B) DUE TO <b>after cholecystectomy and diagnosis for</b> <b>2 weeks</b>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE <b>empyema of gallbladder</b> (C) DUE TO <b>after cholecystectomy and diagnosis for</b>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION <b>12-10-55</b>		19b. MAJOR FINDINGS OF OPERATION <b>empyema of gallbladder, 1 stone in gallbladder neck, drained</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>(If either, notify medical examiner)</b>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) <b>(County) (State)</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>M.</b>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>12-10-1955</b> to <b>12-23-1955</b> , that I last saw the deceased alive on <b>12-27-1955</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.					
SIGNATURE <i>L. Phillips</i> ADDRESS (Street, city, town, state) <b>57 Green St. Cumberland Md.</b> DATE SIGNED <b>12-28-55</b>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Dec 28 1955</b>		NAME OF CEMETERY OR CREMATORIAL <b>St. Peter &amp; Paul Cem</b>	
24. REC'D BY REGISTRAR <b>Dec. 27, 1955</b>		REGISTRAR'S SIGNATURE <b>Walter R. Tracy, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>J. M. B. Right</b>	
ADDRESS <b>Cumberland, Md.</b>					

THE U. S.

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REGULATED

11434

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11452

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 7

## 1. PLACE OF DEATH:

COUNTY Allegany MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) (In this place)  
 TOWN Cumberland 1 yr.

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 917 Virginia Ave.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany  
 CITY (If outside corporate limits write RURAL and give nearest town)  
 OR  
 TOWN Cumberland

STREET ADDRESS (If rural, give location)  
 917 Virginia Ave.

## 3. NAME OF DECEASED: (First) (Middle) (Last)

(Type or Print) James W. Mercure Sr.

4. DATE (Month) (Day) (Year) OF DEATH Dec. 7 1955

## 5. SEX: 6. COLOR OR RACE: 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

Male

white

10a. USUAL OCCUPATION (Give kind of work done during most of work life, Brakeman: Brakeman

10b. KIND OF BUSINESS OR INDUSTRY: B&amp;O R.R.

8. DATE OF BIRTH: Aug. 7-1910

9. AGE last birthday: 45 yrs.

10. IF UNDER 1 YEAR Months Days Hours Min.

## 13. FATHER'S NAME:

Michael Mercure

## 14. MOTHER'S MÄIDEN NAME:

Rose Grimes

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

## 16. SOCIAL SECURITY NO.: 234-12-0996

## 17. INFORMANT &amp; ADDRESS:

Records in his room.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1 Immediate cause (a) Myocardial infarction  
 DUE TOAntecedent cause(s) (b) coronary occlusion.  
 Diseases or conditions, if any, (b) giving rise to the above cause DUE TO

stating underlying cause last (c)

INTERVAL BETWEEN  
 ONSET AND DEATH  
 sudden

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes  No 21a. EXTERNAL CAUSE WAS PRIMARY  or CONTRIBUTING  21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY 21c. (City or town) (County) (State)21d. TIME (Month) (Day) (Year) (Hour) OF INJURY While at Not while M. work  at work  21e. INJURY OCCURRED

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and find that death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined cause   
 SIGNATUREH. V. Deming M.D. *H. V. Deming M.D.* CHIEF MEDICAL EXAMINER   
 DEPUTY MEDICAL EXAMINER  DATE SIGNED *Dec. 7-1955*  
 M. D. ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF 12-10-55 NAME OF CEMETERY OR CREMATORIAL Sanders Cem. LOCATION (City, town, or county) (State) Near Tunnelton, W. Va.

DATE REC'D BY LOCAL REG. 12-9-55 REGISTRAR'S SIGNATURE *Hunter L. Grantly, M.D.* 24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli Cumberland, Md.

BUREAU V. S.

DEC 12 1955

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be examined within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11453

## 11457 CERTIFICATE OF DEATH

Reg. Dist. No. 6

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY		Allegany		STATE		Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town)				CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN		Luke		LENGTH OF STAY (in this place)		Luke II	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Pratt Street		STREET ADDRESS		(If rural give location)	
3. NAME OF DECEASED (Type or Print)		(First) CARL (Middle) GILLEAD (Last) MILLER		4. DATE (Month) (Day) (Year)			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
Male		White		Married		21 July 1908	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. KIND OF BUSINESS OR INDUSTRY		12. BIRTHPLACE (State or foreign country)	
47 yr.		Merchant		Grocery		Bloomington, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO.			
Oliver G. Miller		Florence Duckworth		No		236-03-3999	
17. INFORMANT & ADDRESS				18. MEDICAL CERTIFICATION			
Mrs. Mary Lee Miller, Luke, Md.				Cerebral hemorrhage Hypertensive cardiovascular disease.			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
M.				21a. INJURY OCCURRED While Not while at work at work			
21e. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from Dec. 10, 1955, to Dec. 11, 1955, that I last saw the deceased alive on Dec. 11, 1955, and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
SIGNATURE <i>James A. DeBunkin Jr. MD</i> ADDRESS (Street, city, town, state) DATE SIGNED (Street, city, town, state) 12/11/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		M.D. Green Street, Piedmont, W. Va. 12/11/55			
Burial		12-14-55		LOCATION (City, town, or county) Lount Laym Cemetery, Raleigh, North Carolina			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
DATE 12-12-55		Mr. George Kelly		El. Boral Westernport, Md.			

BUREAU V. S.

DEC 14 1959

REGELV FILE

## INSTRUCTIONS

Report to DEPT.

24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

VS AFSC 1-55 10th

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11454

## 11435 CERTIFICATE OF DEATH

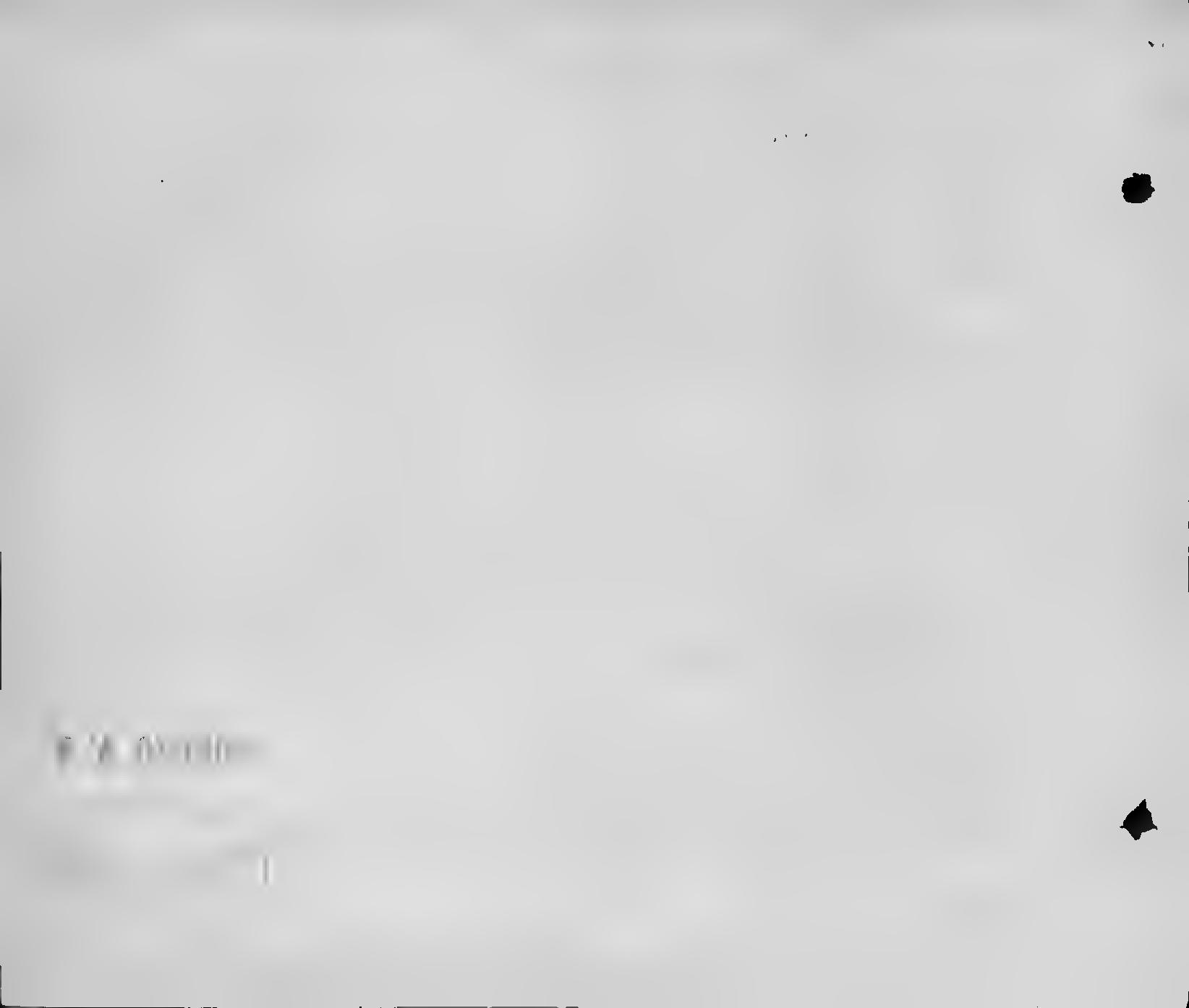
Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (In this place) 9 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND		(If rural give location) STREET ADDRESS 451 HENDERSON AVE.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH DEC. 18 1955			
5. SEX MALE		6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED		8. DATE OF BIRTH 11/17/1892	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Crystal LAUNDRY				10b. KIND OF BUSINESS OR INDUSTRY LAUNDRY			
13. FATHER'S NAME JOSEPH MYERS				11. BIRTHPLACE (State or foreign country) MARYLAND			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
16. SOCIAL SECURITY NO. 214-05-4538				17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, MEMORIAL AVE.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 5.0.1 IMMEDIATE CAUSE (A) <i>Pyloric obstruction</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <i>gastric ulcer with necrosis and scarring</i> GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH Sev. weeks.							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
21a. DATE OF OPERATION 1/15 Dec 55		19b. MAJOR FINDINGS OF OPERATION <i>Pyloric obstruction due to large gastric ulcer</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OR INJURY street, office bldg., etc.)		21d. WHERE DID INJURY OCCUR? (City or town) 18:50 A.M.			
21e. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21f. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21g. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 14 Dec 1955, to 18 Dec 1955, that I last saw the deceased alive on 17 Dec 1955, and that death occurred at 8:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city, town, state) 232 Baltimore Ave. Cumberland Md 18 Dec 55 DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec 21 1955		NAME OF CEMETERY OR CREMATORIAL Baltimore Burial Park		LOCATION (City, town, or county) Cumberland, Md (State)	
24. REC'D BY REGISTRAR Dec 19, 1955		REGISTRAR'S SIGNATURE Walter R. Grant, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md.		ADDRESS	

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## MARYLAND STATE DEPARTMENT OF HEALTH

11456

11469

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 304

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BUNTING

1. PLACE OF DEATH COUNTY Allegany		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) X TOWN Star Route Hancock Md.		LENGTH OF STAY (in this place) Life	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home		3. NAME OF DECEASED (First) James	
		(Middle) Albert	
4. SEX M		5. COLOR OR RACE W	
6. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		7. KIND OF BUSINESS OR INDUSTRY Farming	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. AGE last birthday Oct. 5 1884 71 yrs.	
13. FATHER'S NAME Jonas Potts		8. DATE OF BIRTH Oct. 5 1884	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No (If yes, give war or dates of service)		9. AGE last birthday If under 1 year Months 2 Days 2 Hours 55 Min.	
16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) Allegany County Maryland	
		12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/> U.S.A.	
17. INFORMANT AND ADDRESS Mrs Margaret F Potts Star Route Hancock Md.		14. MOTHER'S MAIDEN NAME Margaret Keefer	
18. MEDICAL CERTIFICATION  I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  422.2 Immediate cause (a)  Antecedent cause(s) Diseases or conditions, if any, (b) giving rise to the above cause stating the underlying cause last (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION  Nitral Siccans Chronic Myocarditis 20 day 12/1/78	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1938, 19, to 1953, 19, that I last saw the deceased alive on Nov 22, 1953, and that death occurred at m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED H E Heller, M.D. 12/1/78			
23. BURIAL Cremation REMOVAL (Specify) Funeral		DATE THEREOF 12/1/78	
DATE REC'D BY LOCAL REG. NO.		NAME OF CEMETERY OR CREMATORIUM St Patrick Cemetery	
REG. NO.		LOCATION (City, town, or county) Little Orleans Md. (State)	
REG. NO.		24. FUNERAL DIRECTOR ADDRESS Howard & Son Hancock Md.	

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**INSTRUCTIONS**

With this copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

The bottom copy may be retained by the hospital or attending physician.

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

11457

**11436 CERTIFICATE OF DEATH**

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN HOSPITAL INSTITUTION OR STREET ADDRESS	Allegany Cumberland, 6 Va. Ave.,	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS
C2		Cumberland, 6 Virginia Ave., (If rural give location)	
<b>3. NAME OF DECEASED (Type or Print)</b>		<b>4. DATE OF DEATH</b>	
(First) JAMES (Middle) DAVID (Last) PUGH		Dec. 9, 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb. 6, 1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi driver		10b. KIND OF BUSINESS OR INDUSTRY Yellow Top Cab.	9. AGE last birthday 45 yrs.
11. BIRTHPLACE (State or foreign country) Salem, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James L. Pugh		14. MOTHER'S MAIDEN NAME Ethel Stone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No,		16. SOCIAL SECURITY NO. 220-07-1180	
17. INFORMANT & ADDRESS Mrs. Audra Pugh 6 Va. Ave., Cumb. Md.		18. MEDICAL CERTIFICATION Hypertension Chronic Myocarditis Chronic Nephritis	
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.2 IMMEDIATE CAUSE (A) DUE TO ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) DUE TO GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 mos 6 yrs 4 yrs	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. PLACE (Home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 9, 1955</u> to <u>Dec. 9, 1955</u> , that I last saw the deceased alive on <u>Dec. 9, 1955</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Charles L. Frank, M.D.</u> DATE SIGNED <u>12/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/12/55	NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park
24. REC'D BY REGISTRAR DATE Dec. 12, 1955		REGISTRAR'S SIGNATURE Charles L. Frank, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles L. George Cumberland, Md.

BUREAU V. S.

DEC 14 1965

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**INSTRUCTIONS****TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

11458

**11437 CERTIFICATE OF DEATH**

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Cumberland		3 yrs		TOWN Cumberland		TOWN Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 105 5th St.		STREET ADDRESS 105 5th St.		(If rural give location)			
<b>3. NAME OF DECEASED (Type or Print)</b> Eliza Alice Rexroad				<b>4. DATE OF DEATH</b> 10-23, 1955			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH March 15, 1875	9. AGE last birthday 80	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. (Year) Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Franklin, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Geo. Moyer				14. MOTHER'S MAIDEN NAME Mary F. Rexroad			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mary F. Doman 1st 5th St. City			
<b>18. MEDICAL CERTIFICATION</b> <i>CHRONIC Myocarditis ten years</i>							
INTERVAL BETWEEN ONSET AND DEATH							
<b>I</b> DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) Baltimore		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Dec. 21, 1955			
22. I hereby certify that I attended the deceased from alive on Dec. 25, 1955, and that death occurred at 12:30 A.M. from the causes and on the date stated above. SIGNATURE <i>E. Broadbent M.D.</i>							
ADDRESS (Street, city, town, state) <i>Baltimore, Md.</i> DATE SIGNED <i>12-23-55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10-26-55		NAME OF CEMETERY OR CREMATORIUM Fort Ashby Cem.		LOCATION (City, town, or county) Fort Ashby W. Va.	
24. REC'D BY REGISTRAR Dec. 26, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE James F. Scarcelli, M.D.		ADDRESS Cumberland, Maryland	

BURDAU V. 8

DE SILEVLE

## 11438 CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>		<b>2. PRELIMINARY INQUIRIES</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cumberland		STATE West Virginia COUNTY Grant CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Petersburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital		STREET ADDRESS (If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) BABY		<b>4. DATE</b> (Month) (Day) (Year) OF DEATH DECEMBER 22, 1955	
(First) (Middle) (Last)		5. SEX Female	
6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	
8. DATE OF BIRTH Dec. 22, 1955		9. AGE last birthday yrs. Months Deyrs Hours Min 1 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jesse Riggelman		14. MOTHER'S MAIDEN NAME Mary Lynn Bane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Memorial Hospital		18. MEDICAL CERTIFICATION IMMEDIATE CAUSE (A) Anencephaly ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) M.D. 3 Greene St. Curb. Id. Dec. 24, 1955	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 22, 1955</u> , to <u>Dec. 24, 1955</u> , that I last saw the deceased alive on <u>Dec. 22, 1955</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city, town, state) <u>AM</u> SIGNATURE <u>Zelma A. Lanson</u> DATE <u>Dec. 24, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 24, 1955	
24. REC'D BY REGISTRAR DATE <u>Dec. 24, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter F. Frantz, M.D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		LOCATION (City, town, or county) Petersburg, West Virginia.	

1. **INSTRUCTIONS**  
The bottom copy may be retained by the hospital or attending physician.2. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-35 10th

RECEIVED

DEC 3 1955

BUREAU V 8









Within corporate limits

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

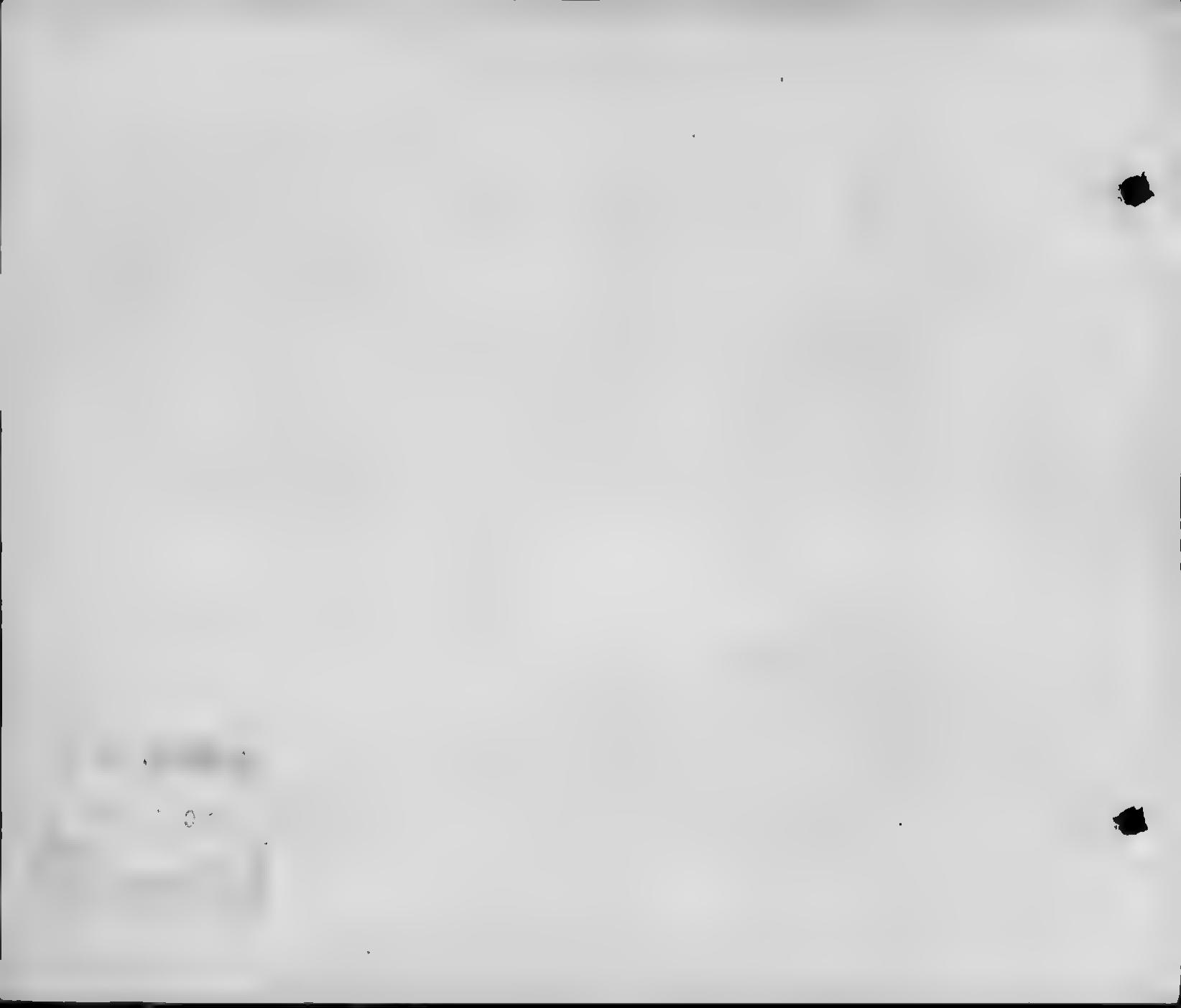
Reg. Dist.

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**L WRITE PLAINLY, WITH UNFAADING INK.** Supply every item of information carefully. The cause of death especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:								
COUNTY	Allegany	MARYLAND	STATE	Kd.	COUNTY	Allegany				
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		LENGTH OF STAY (in this place) months	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural) Cumberland							
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Dead on arrival at the Memorial Hospital.								
3. NAME OF DECEASED: (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)		
Marily				Scheurling	Dec.	4	19	55		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.				
Female	white	Married	May 12-1905	50	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?				
Housewife				Mt Savage, Md.		U.S.A.				
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:								
Francis P. Reynolds		Emma Porter								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION				
No				R. T. P. #1 Braddock Far- (husband) Lloyd E. Scheurling,						
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  391X Immediate cause (a) Cerebral hemorrhage (Apoplexy) DUE TO Antecedent cause(s) Diseases or conditions, if any, (b) _____ giving rise to the above cause DUE TO _____ stating underlying cause last (c) _____									INTERVAL BETWEEN ONSET AND DEATH about 1/2 hr.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH										
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:							20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County)					(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?						
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> SIGNATURE H.V. Deming M.D. <i>H.V. Deming M.D.</i>									CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.	DATE SIGNED Dec. 5-1955
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 12-9-55	NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		LOCATION (City, town, or county) Cumberland, Maryland				(State)	
DATE RECD BY LOCAL REG.		REG.		REG.	24. FUNERAL DIRECTOR		ADDRESS			
Dec. 7, 1955		Winter R. Tracy, M.D.		REG.	James F. Scarpelli, Cumberland, Md.					



## INSTRUCTIONS

1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. All this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 4-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11463

## 11442 CERTIFICATE OF DEATH

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b> COUNTY <u>Allegany</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cumberland</u> LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>314 Baltimore Ave</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> STATE <u>Md</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u> STREET ADDRESS <u>314 Baltimore Ave</u> (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) <u>Paul</u> (Middle) <u>Jacob</u> (Last) <u>Schultz</u> (Type or Print)				<b>4. DATE OF DEATH</b> <u>Dec 24</u> (Month) <u>1955</u> (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>July 24, 1895</u>	9. AGE last birthday <u>60</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>yard Master</u>	11. KIND OF BUSINESS OR INDUSTRY <u>B&amp;O Railroad</u>	12. BIRTHPLACE (State or foreign country) <u>Cumberland</u>
<b>13. FATHER'S NAME</b> <u>Frederick Schultz</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Bertha Foltermann</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>World War I</u>				<b>16. SOCIAL SECURITY NO.</b> <u>705-05-8056</u>			
<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs Paul J Schultz - Cumberland</u>				<b>18. MEDICAL CERTIFICATION</b> <u>Carcinoma of Rectum - given by</u> <u>Metastasis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> IMMEDIATE CAUSE <u>(A)</u> <u>Carcinoma</u> ANTECEDENT CAUSE(S) DUE TO <u>Metastasis</u> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. <u>(C)</u>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Diabetes Mellitus</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b> <u>M.</u>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from.....</b> <u>Sept 1955</u> <b>to.....</b> <u>Dec 1955</u> , <b>that I last saw the deceased alive on</b> <u>Dec 23, 1955</u> , <b>and that death occurred at</b> <u>5:15 P.M.</u> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>John F. Hafer</u> <b>ADDRESS</b> <u>133 Va Ave, Cumberland, Md</u> <b>DATE SIGNED</b> <u>12/24/55</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>12/28/55</u>		<b>NAME OF CEMETERY OR CREMATORIUM</b> <u>St. Marys Catholic Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Cumberland Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John F. Hafer</u> <b>ADDRESS</b> <u>Cumberland Md</u>			
<b>DATE</b> <u>Dec 27, 1955</u>		<b>Walter R. Franky, M.D.</b>					

REGGIE FORD

Burnett Y. S.

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 15-510M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11464

## 11443 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		Md.		Allegany	
TOWN Cumberland, Md.		7 months		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN Cumberland, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		11 Seymour Street		STREET ADDRESS		118 Seymour St.	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
Alvin Lee Sensabaugh				12-14-55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		19
Male	White	single	May 6, 1955	yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			
none		none		Cumberland, Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John A. Sensabaugh				Hazel Jean Sensabaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		none		John A. Sensabaugh, Cumberland, Md.			
18. MEDICAL CERTIFICATION							
<p>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>IMMEDIATE CAUSE (A) <u>Pulmonary Congestion-Acute</u>            ANTECEDENT CAUSE(S) DUE TO <u>Acute Laryngotracheal Bronchitis</u>            DISEASES OR CONDITIONS, IF ANY, (B) <u></u>            GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u></u>            (C) <u></u></p> <p>INTERVAL BETWEEN ONSET AND DEATH Minute. 24hr.</p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 14, 1955, to Dec. 14, 1955, that I last saw the deceased alive on Dec. 14, 1955, and that death occurred at 12:00 P.M. from the causes and on the date stated above. SIGNATURE: <u>John A. Sensabaugh</u> ADDRESS (Street, city, town, state) <u>M.D. 1334a One, Cumberland, Md.</u> DATE SIGNED <u>12/14/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)			
Burial		12-15-55		Hillcrest Burial Pk. Cumberland, Md.			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
Dec. 15, 1955		Walter J. Ladd		John J. Largess			



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11465

## 11470 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Allegany</b> CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <b>Rural-Cumberland</b>		STATE <b>Maryland</b> COUNTY <b>Allegany</b> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Rural-Cumberland</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Rt. 4, Mexico Farms, Cumberland, Md.</b>		STREET ADDRESS <b>Rt. 4, Mexico Farms, Cumberland, Md.</b>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<b>Mary Frances Shank</b> (First) (Middle) (Last)		(Month) (Day) (Year) <b>Dec. 15 1955</b>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<b>F</b>	<b>W</b>	<b>Married</b>	<b>June 4, 1883</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<b>Housewife</b>		<b>Own Home</b>	<b>La Vale, Maryland</b>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<b>Francis M. DeVore</b>		<b>Rachel E. Everstine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
<b>NO</b>		<b>None</b>	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
		<b>Pulmonary Embolism</b> <b>Hemorrhage</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21c. WHERE DID INJURY OCCUR? (City or town) (County) <b>Cumberland, Md.</b> (State) <b>Md.</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Nov. 15, 1955</b> , to <b>Dec. 15, 1955</b> , that I last saw the deceased alive on <b>Nov. 15, 1955</b> , and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above.		<b>ADDRESS</b> (Street, city, town, state) <b>Cumberland, Md.</b> <b>DATE SIGNED</b> <b>12/16/55</b> <b>SIGNATURE</b> <b>W.M. Hodges</b> <b>M.D.</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>12/18/55</b> NAME OF CEMETERY OR CREMATORIAL <b>Hose Hill Cemetery</b> LOCATION (City, town, or county) <b>Cumberland, Md.</b> (State) <b>Md.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <b>Walter R. Frank, M.D.</b> 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John J. Hafer, Cumberland, Md.</b>	
<b>Dec. 17, 1955</b>			



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11466

## 11471 CERTIFICATE OF DEATH

Reg. Dist. No. 6

## 1. PLACE OF DEATH

COUNTY Allegany  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN Moscow  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 00

MARYLAND

LENGTH OF STAY  
 (In this place)  
28 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md COUNTY Allegany  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN Moscow  
 STREET ADDRESS    
 (If rural give location)

3. NAME OF  
 DECEASED  
 (Type or Print)

(First) Mary (Middle) Lauder (Last) Shaw

4. DATE (Month) (Day) (Year)  
 OF DEATH Dec 30 19 55

5. SEX Female6. COLOR OR  
 RACE White7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED,  
 (Specify) Widow

8. DATE OF BIRTH

July 7, 18769. AGE last birthday  
 79 yrs.10. IF UNDER 1 YEAR  
 Months   Days   Hours   Min.  10a. USUAL OCCUPATION (Give kind of work  
 done during most of working life, even if  
 retired) Domestic10b. KIND OF BUSINESS  
 OR INDUSTRY Our home

11. BIRTHPLACE (State or foreign country)

Ridlesburg, Pa12. CITIZEN OF WHAT  
 COUNTRY? U.S.

13. FATHER'S NAME

William Launder

14. MOTHER'S MAIDEN NAME

Mary Aschem Launder15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
 (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

Andrew Shaw, Moscow, Md

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE Coronary ThrombosisANTECEDENT CAUSE(S) DUE TO ArteriosclerosisDISEASES OR CONDITIONS, IF ANY, DUE TO  GIVING RISE TO THE ABOVE CAUSE DUE TO  STATING UNDERLYING CAUSE LAST.  (C)  

## 18. MEDICAL CERTIFICATION

INTERVAL BETWEEN  
 ONSET AND DEATH1 Day10 yrsII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 YES  NO 

(State)

21a. ACCIDENT WAS UNDERLYING   
 OR CONTRIBUTING  CAUSE OF DEATH  
 (If either, notify medical examiner)21b. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.)21c. WHERE DID INJURY OCCUR? (City or town)  
 (County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
 While  Not while   
 at work  at work M. et work at work

9



BUREAU V. S

EC 14 1955

DEPARTMENT OF JUSTICE

## INSTRUCTIONS

1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.3. **VS A15C 155 10A** The bottom copy may be retained by the hospital or attending physician.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

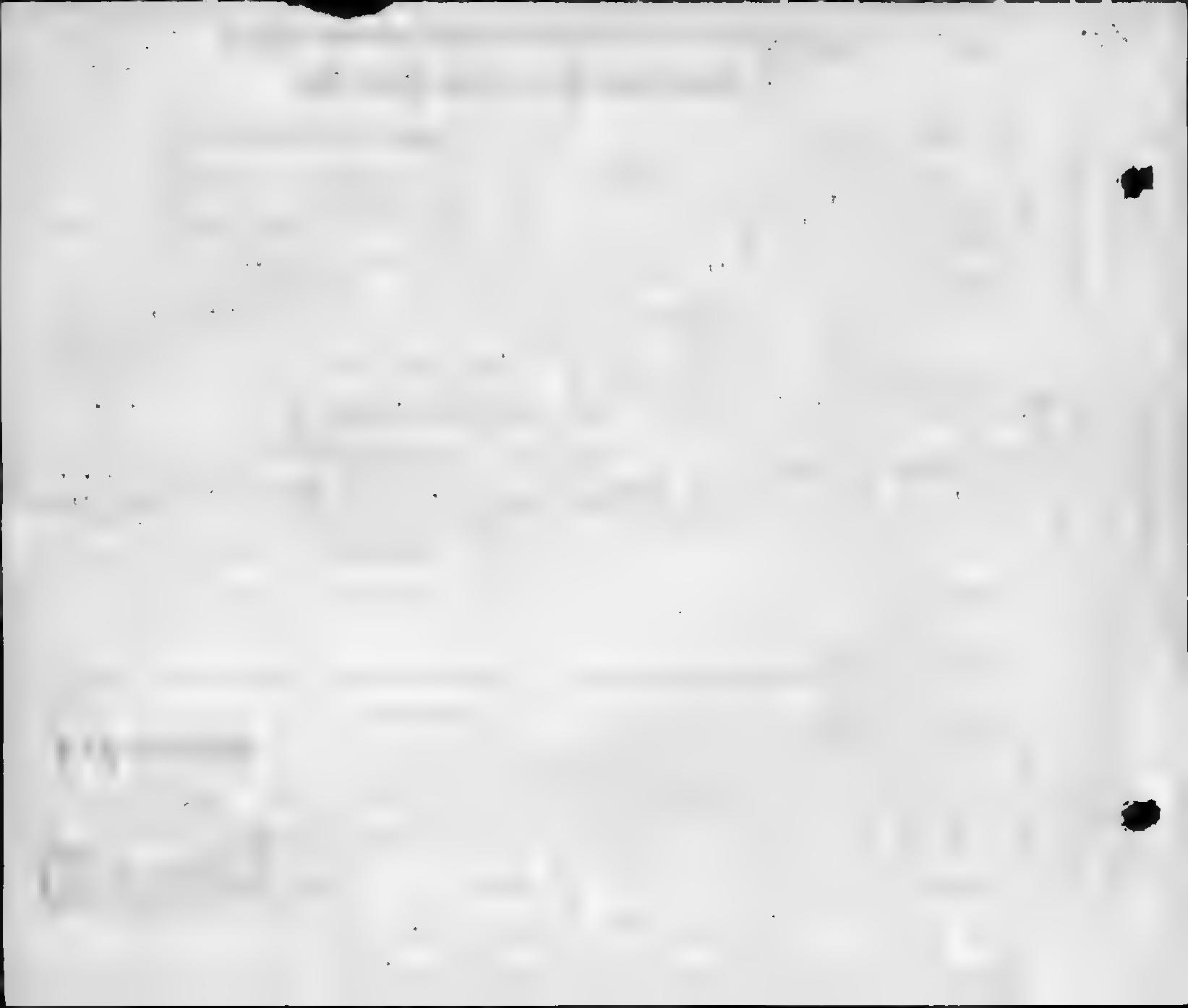
11444

11468

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		Allegany		MARYLAND		STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town)				LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Cumberland,						TOWN Cumberland,	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
36 Greene St.,				36 Greene St.,			
				(If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)			
CHARLES FREDERICK WILLIAM SNYDER				Dec. 10, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White		May 19, 1884	71	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		Medicine		Accident, Maryland		U. S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Adam Snyder				Elizabeth Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		Cumberland, Md.	
No,		None		Mrs. Planche Snyder		36 Greene St.,	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Diabetes mellitus, dilatation</i> <i>As it is due</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Diabetes, Cardio-vascular</i> <i>syndrome</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>disease</i> <i>1 year</i>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		19c. WHERE DID INJURY OCCUR? (City or town)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						(County) (State)	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)			
						(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan. 10, 1955</i> to <i>Dec. 10, 1955</i> , that I last saw the deceased alive on <i>Dec. 10, 1955</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Walter R. Enhart</i> M.D. ADDRESS (Street, city, town, state) <i>36 Greene St., Cumberland, Md.</i> DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/13/55		NAME OF CEMETERY OR CREMATORIUM Trinity Lutheran Cem.		LOCATION (City, town, or county) Cumberland, Maryland (State)	
24. REC'D BY REGISTRAR Dec. 15, 1955		REGISTRAR'S SIGNATURE <i>Walter R. Enhart, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Maryland	



Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11445

CERTIFICATE OF DEATH

11469

Reg. Dist. No. 4

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED							
COUNTY		MARYLAND		STATE		COUNTY					
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		Maryland		Allegheny					
TOWN Cumberland											
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS							
110 So. Johnson St.,				110 So. Johnson St.,							
(First) (Middle) (Last)				(If rural give location)							
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)							
ADDA ELIZABETH SOWERS				DECEMBER 23, 1955							
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.				
Female	White	Married	Oct. 27, 1891	64 yrs.	Months	Days	Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
Housewife			Own home		Hampshire Co. W. Va.			U. S.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Samuel H. Largent				Susanna Thomas							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.			17. INFORMANT & ADDRESS			INTERVAL BETWEEN ONSET AND DEATH		
(If Yes, give war or dates of service)			None			Miss Betty Sowers 110 S. Johnson St.,			Cumberland, Md.		
18. MEDICAL CERTIFICATION											
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH											
420.1 IMMEDIATE CAUSE (A) <i>coronary thrombosis</i>											
ANTECEDENT CAUSE(S) DUE TO											
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE											
STATING UNDERLYING CAUSE LAST. DUE TO (C)											
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.											
<i>Bronch - pneumonia</i>											
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			(State)		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town)			(County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?					
M.											
22. I hereby certify that I attended the deceased from <i>January 19, 1955</i> , to <i>Dec 23, 1955</i> , that I last saw the deceased alive on <i>Dec 22, 1955</i> , and that death occurred at <i>9:30 A.M.</i> from the causes and on the date stated above.											
SIGNATURE <i>B. M. Schubert</i> M.D.										ADDRESS (Street, city, town, state) <i>44 Green St. Cumberland, Md.</i> DATE SIGNED <i>4/3/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL			LOCATION (City, town, or county)			(State)	
Burial		12/26/55		Hillcrest Burial Park			Cumberland, Maryland				
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS				
DATE <i>Dec 26, 1955</i>		<i>Katherine Gandy, R.D.</i>		<i>H. Wayne George</i>			<i>Cumberland, Md.</i>				

Family A. 8

GC ~ 100

**INSTRUCTIONS****TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

Within corporate limits.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AFSC 155. IWH

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

11446

**CERTIFICATE OF DEATH**

11470

Reg. Dist. No. 4

DR. R.J. WILLIAMS

**1. PLACE OF DEATH**

COUNTY ALLEGANY

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)LENGTH OF STAY  
(In this place)

TOWN CUMBERLAND

24 DAYS

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

MEMORIAL HOSPITAL

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE MARYLAND

COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR

TOWN CUMBERLAND

STREET  
ADDRESS

(If rural give location)

33 VIRGINIA AVENUE

**3. NAME OF  
DECEASED**(First)  
(Type or Print)

ANDREW

W. SPEARMAN

(Last)

**4. DATE  
OF  
DEATH**(Month)  
(Day)  
(Year)

DECEMBER 14 1955

5. SEX  
MALE6. COLOR OR  
RACE  
WHITE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED  
(Specify) SINGLE8. DATE OF BIRTH  
NOVEMBER 6, 19059. AGE last birthday  
50 yrs.10. IF UNDER 1 YEAR  
Months  
Days  
Hours  
Min.10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired) ELECTRICIAN10b. KIND OF BUSINESS  
OR INDUSTRY  
B & O.R.R.CO.11. BIRTHPLACE (State or foreign country)  
MARYLAND12. CITIZEN OF WHAT  
COUNTRY?  
U.S.A.

## 13. FATHER'S NAME

ANDREW P. SPEARMAN

## 14. MOTHER'S MAIDEN NAME

ROSE NASH

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

705-05-4368

## 15. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

525x IMMEDIATE CAUSE (A)

Gronary Thrombosis

INTERVAL BETWEEN  
ONSET AND DEATH

immediate

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. DUE TO

(C)

Car Pulmonary

1mo

Pulmonary Fibrosis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

## 21e. INJURY OCCURRED

## 21f. HOW DID INJURY OCCUR?

M. While at work  Not while at work 

## 22. I hereby certify that I attended the deceased from

11/19/55, 19....., to 12/19/55 19....., that I last saw the deceased

alive on 11/19/55, 19....., and that death occurred at 11:30PM, from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL/CREMATION,  
REMOVAL (SPECIFY)

Burial

## DATE THEREOF

12-19-55

## NAME OF CEMETERY OR CREMATORI

St Peter &amp; Paul Cem.

## LOCATION (City, town, or county)

Cumberland, d.

(State)

## 24. REC'D BY REGISTRAR

Dec. 19, 1955

## REGISTRAR'S SIGNATURE

Walter R. Frank, M.D.

## 25. FUNERAL DIRECTOR'S SIGNATURE

James F. Scarcelli Cumberland, d.

ADDRESS



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

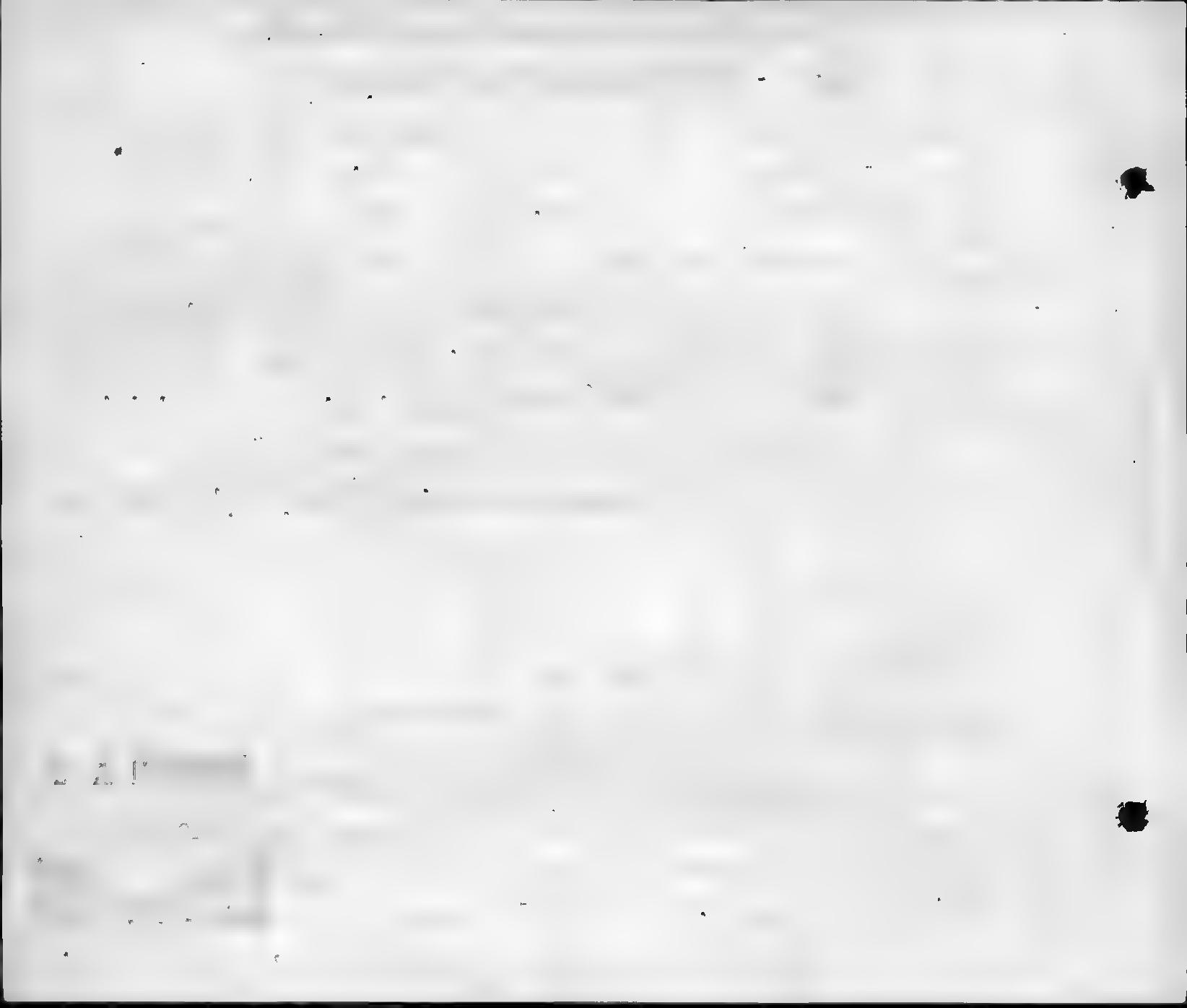
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11471

## 11473 - CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Allegany	STATE	MD.
CITY (If outside corporate limits, write RURAL OR and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN	Lenaconing	TOWN	Lenaconing
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
East Main Street		East Main Street	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) CATHERINE		(Month) (Day) (Year) March 20th 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White	Single	March 4th. 1884
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if Retired Manager of Cafeteria (School) Nikep, MD.		11. BIRTHPLACE (State or foreign country)
71 yrs			U.S.A.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
James Stevenson		Elizabeth Mackey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)			
17. INFORMANT & ADDRESS			
Mrs. Daniel Stakem, Sister			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A)			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO			
(C)			
Coronary Occlusion			
Arteriosclerosis - Coronary.			
INTERVAL BETWEEN ONSET AND DEATH			
10 min			
2 year			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
Diabetes Mellitus.			
19a. DATE OF OPERATION			
19b. MAJOR FINDINGS OF OPERATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from August 1955 to Dec 1955, that I last saw the deceased alive on Dec 1955, and that death occurred at 8:20 P.M. from the causes and on the date stated above. SIGNATURE: George Eichhorn M.D. ADDRESS (Street, city, town, state) 12-22-55 DATE SIGNED			
23. BURIAL, CREMATION REMOVAL (SPECIFY) Burial			
DATE THEREOF Dec, 23. 1955			
NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery			
LOCATION (City, town, or county) Lenaconing, MD. (State)			
24. REC'D BY REGISTRAR			
REGISTRAR'S SIGNATURE Jennifer M. Boul			
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS GEORGE EICHORN, Lenaconing, MD.			
DATE 12-23-55			



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11458 CERTIFICATE OF DEATH

11472  
9

Reg. Dist. No. ....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	Allegany	MARYLAND LENGTH OF STAY (In this place)	Maryland COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg, 22
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Frostburg, 22	15 yrs.	STREET ADDRESS (If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last)		Month (Day) (Year)	
Elsie May Stewart		Dec. 3rd, 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White	Married	March 21st, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housewife		Housework	Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Owen Lewis		Elizabeth Porter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		None	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
Allen Stewart, Frostburg, Md.		Generalized Scleroderma 5 yrs.	
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
710.0 IMMEDIATE CAUSE (A) Generalized Scleroderma		3 yrs.	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		Chronic Glomerulonephritis 3 yrs.	
21a. DATE OF OPERATION		21b. MAJOR FINDINGS OF OPERATION	
21c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 1, 1955</u> , to <u>Dec. 3, 1955</u> , that I last saw the deceased alive on <u>Dec. 3, 1955</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Martin Mottat</u> M.D. ADDRESS (Street, city, town, state) <u>48 Broadway - Frostburg, Md.</u> DATE SIGNED <u>12/4/55</u>			
23. BURIAL/CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM
Burial		12-5-1955	Eckhart Cemetery
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE
DATE <u>12-5-55</u>		ADDRESS <u>Mr. Nancy A. Rod</u> Joseph R. Durst, Frostburg, Md.	

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**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

1. **WHEN TO FILE:** After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy (detached from the assembly) should be detached for use as a burial transit permit.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy (detached from the assembly) should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

11447

11473

**CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN CUMBERLAND		MARYLAND LENGTH OF STAY (In this place) 11 DAYS		STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WESTERNPORT		COUNTY ALLEGANY (If rural give location) 43 120 JOHNSON ST.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL AVE.				STREET ADDRESS			
3. NAME OF DECEASED (First) (Middle) (Last) MRS ODA B. SULLIVAN				4. DATE OF DEATH DEC. 2. 19 55			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH SEPT. 15, 1888	9. AGE last birthday 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) WEST VIRGINIA			
13. FATHER'S NAME LEONARD VANNOY				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT & ADDRESS Memorial Hospital				18. MEDICAL CERTIFICATION Cerebral vascular m. t. b. a. 3 m. m. i. Cerebral, Trig. D. S. I. 12 m. s. t.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 153X IMMEDIATE CAUSE (A) Cerebral vascular m. t. b. a. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH 3 m. m. i. 12 m. s. t.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cerebral failure							
19a. DATE OF OPERATION 13-12-55		19b. MAJOR FINDINGS OF OPERATION Cerebral vascular m. t. b. a.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) 2.32 Baltimore Ave.		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-12</u> , 19 55, to <u>Dec. 3</u> , 19 55, that I last saw the deceased alive on <u>Dec. 2</u> , 19 55, and that death occurred at <u>10:18 AM</u> from the causes and on the date stated above. ADDRESS (Street, city, town, state) <u>2.32 Baltimore Ave.</u> <u>Dec. 3 1955</u> DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 5, 1955</u>		NAME OF CEMETERY OR CREMATORIUM <u>St. Peter Cemetery</u>		LOCATION (City, town, or county) <u>Westernport Ave., Md.</u> (State)	
24. REC'D BY REGISTRAR <u>Dec. 4, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter L. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Harold Reddick Jr.</u>		ADDRESS	





BUHLER & CO.

INC.

REG. U. S. PAT. OFF.

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the minister within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

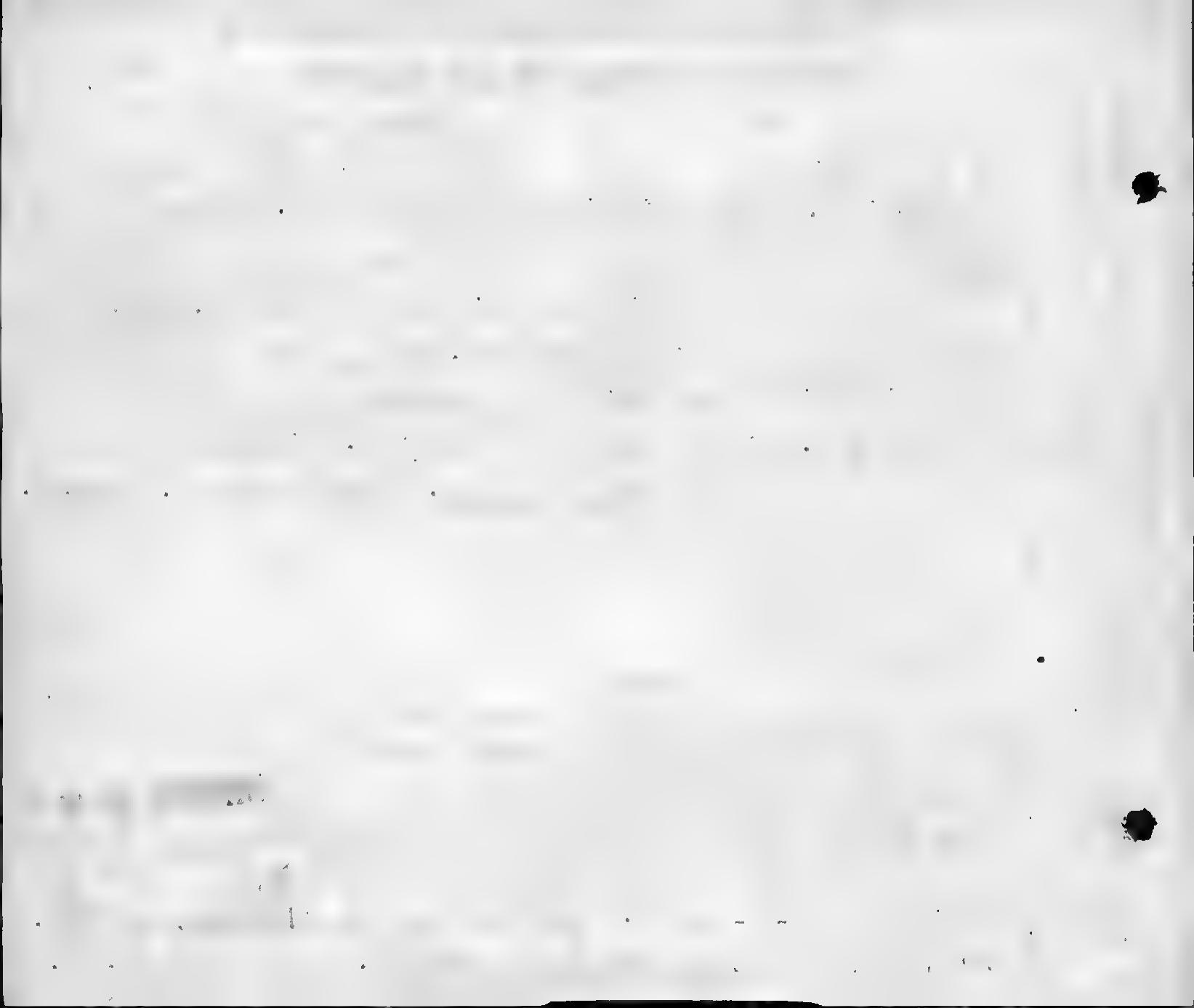
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11474 CERTIFICATE OF DEATH

11475

Reg. Dist. No. 9

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town)		MARYLAND LENGTH OF STAY (In this place)		STATE CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		COUNTY Maryland Allegany (Rural) Mt. Savage	
X TOWN (Rural) Mt. Savage		Lifetime		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
<b>3. NAME OF</b> (First) Jesse Earl Trimble (Type or Print)				<b>4. DATE</b> (Month) (Day) (Year) OF DEATH Dec. 22nd, 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 8th, 1887	9. AGE last birthday 68 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired miner	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George T. Trimble				14. MOTHER'S MAIDEN NAME Helen A. Trimble			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT & ADDRESS (Rural) Mrs. Susanna Trimble, Mt. Savage, Md.				18. MEDICAL CERTIFICATION Cerebral Hemorrhage Chronic Heart Disease 8 days -			
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. DATE OF OPERATION				21b. MAJOR FINDINGS OF OPERATION			
21c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21d. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21e. WHERE DID INJURY OCCUR? (City or town) (County) (State)				21f. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21g. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21h. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 21, 1955, to Dec. 22, 1955, that I last saw the deceased alive on Dec. 21, 1955, and that death occurred at 11:00AM, from the causes and on the date stated above. SIGNATURE John B. Davis, M.D. ADDRESS (Street, city, town, state) Frostburg, Md. DATE SIGNED 12/22/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-24-1955		NAME OF CEMETERY OR CREMATORIUM St. Georges Cemetery		LOCATION (City, town, or county) Mt. Savage, Md. (State)	
24. REC'D BY REGISTRAR Ms. Daisy N. Rus		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS Joseph R. Durst, Frostburg, Md.			
DATE 12-23-55							



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 (104)

11476

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11449 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		ALLEGANY CUMBERLAND	MARYLAND LENGTH OF STAY (In this place) 31 DAYS		STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS		MEMORIAL HOSPITAL		STREET ADDRESS (If rural give location) 109 PARK STREET	
3. NAME OF DECEASED (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)		
SARAH MILDRED TWIGG			12/29/1955		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) DIVORCED	8. DATE OF BIRTH FEBRUARY 15, 1877	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM J. PENNINGTON			14. MOTHER'S MAIDEN NAME BETSY JONES		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND	
18. MEDICAL CERTIFICATION 1999 IMMEDIATE CAUSE (A) <i>Pedunculated Carcinomatosis.</i> 6-8 mo. ANTECEDENT CAUSE(S) DUE TO <i>Primary site unknown.</i> DISEASES OR CONDITIONS, IF ANY, (B) <i>metastatic Ca - generalized abdomen.</i> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
19a. DATE OF OPERATION SEPT, 28, 1955		19b. MAJOR FINDINGS OF OPERATION <i>metastatic Ca - generalized abdomen.</i>		21. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <i>9-19, 1955</i> to <i>12/29, 1955</i> , that I last saw the deceased alive on <i>12/27 1955</i> , and that death occurred at <i>7:35 AM</i> , from the causes and on the date stated above. SIGNATURE <i>John J. Morris</i> ADDRESS (Street, city, town, state) <i>Cumberland Md.</i> DATE SIGNED <i>12/30/55</i>					
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 12/31/55		NAME OF CEMETERY OR CREMATORIAL Hillcrest Cemetery	
24. REC'D BY REGISTRAR Dec. 31, 1955		REGISTRAR'S SIGNATURE <i>Walter F. Frank, M.D.</i>		LOCATION (City, town, or county) Cumberland Maryland	
				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Louis Stein, Inc. Cumberland, Md.	

1920-21

## INSTRUCTIONS

1

within 24 hours after death. Attach this

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS. AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11477

11450

## CERTIFICATE OF DEATH

DR. HODGES

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		ALLEGANY		STATE		MARYLAND	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town)		COUNTY	
TOWN		CUMBERLAND		LENGTH OF STAY (In this place)		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		60 MEMORIAL HOSPITAL		11 DAYS		CUMBERLAND, RURAL	
3. NAME OF DECEASED (First) (Type or Print)				4. DATE OF DEATH			
EDGAR D. VANDEGRIFF				DECEMBER 2, 1955			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
MALE		WHITE		MARRIED		APRIL 3, 1904	
9. AGE last birthday		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
51 yrs.		SELF EMPLOYED		MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN VANDEGRIFF				FRANCES MARTIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unk.)				16. SOCIAL SECURITY NO.			
214-05-6207				17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION				MEMORIAL HOSPITAL - CUMBERLAND, MD.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 177X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Massive intracranial hemorrhage - 2 hrs metastatic lesion brain Carcinoma prostate ? 3 yrs +			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 3/1955		19b. MAJOR FINDINGS OF OPERATION Ca of prostate		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, Term, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) Cumberland		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 5:40AM			
22. I hereby certify that I attended the deceased from 11/1/51, 19 55 to 12/2, 19 55, that I last saw the deceased alive on 12/1, 19 55, and that death occurred at 5:40AM, from the causes and on the date stated above. SIGNATURE <i>W.H. Hodges</i> ADDRESS (Street, City, town, state) <i>Cumberland, Md.</i> DATE/SIGNED <i>12/12/55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/4/55		NAME OF CEMETERY OR CREMATORIAL Hillcrest Cemetery		LOCATION (City, town, or county) Cumberland	
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE <i>Walter F. Gantz, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc.		(State) Maryland ADDRESS Cumberland, Md.	

BUREAU Y.

1955 6-27

THE EASY WAY

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

11478

**11451 CERTIFICATE OF DEATH**

Reg. Dist. No. 4

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Allegany</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL OR give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If rural give location)	
TOWN <b>Cumberland</b>		22 Years		TOWN <b>Cumberland</b>		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>112 Sacred Heart Hospital</b>		STREET ADDRESS		115 Harrison		1	
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> <b>12 6 1955</b>			
(First) <b>Otis</b>		(Middle) <b>H</b>		(Last) <b>Wilfong</b>		(Month) <b>Month</b> (Day) <b>Day</b> (Year) <b>Year</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>8/17/92</b>	9. AGE last birthday <b>63</b> yrs.	IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction Co</b>		11. BIRTHPLACE (State or foreign country) <b>Harman West Virginia</b>	
13. FATHER'S NAME <b>John Wilfong</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Arbogast</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-05-6789</b>		17. INFORMANT & ADDRESS <b>Stanley Wilfong Cumberland, Md.</b>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>151X</b> IMMEDIATE CAUSE (A) <b>Coughing</b>				3 weeks			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <b>Cancer of stomach</b>				3 months			
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Intestinal obstruction</b>							
19a. DATE OF OPERATION <b>11-2-55</b>		19b. MAJOR FINDINGS OF OPERATION <b>colectomy</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) <b>11A</b> (State) <b>Md.</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>10-31-1955</b> to <b>12-6-1955</b> , that I last saw the deceased alive on <b>12-5-1955</b> , and that death occurred at <b>11A</b> M, from the causes and on the date stated above. SIGNATURE <i>John Wilfong</i> ADDRESS <b>57 Green St. Cumberland, Md.</b> DATE SIGNED <b>12-6-55</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Dec 8 1955</b>		NAME OF CEMETERY OR CREMATORIAL <b>Zion Memorial Burial Park</b>		LOCATION (City, town, or county) <b>Cumberland, Md.</b> (State)	
24. REC'D BY REGISTRAR DATE <b>Dec 7, 1955</b>		REGISTRAR'S SIGNATURE <b>W. R. Rantz, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Kight</b>		ADDRESS <b>Cumberland, Md.</b>	

THE GOVERNOR OF THE STATE OF ALABAMA

THE ATTORNEY GENERAL OF THE STATE OF ALABAMA

BUREAU A. G.

DEC 9 1953

RECEIVED